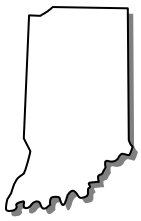
EDS Client Services Department



INDIANA HEALTH COVERAGE PROGRAMS

HealthWatch Early Periodic Screening, Diagnosis, and Treatment Provider Manual

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Revision History

Document Version Number	Revision Date	Revision Page Number(s)	Reason for Revisions	Revisions Completed By
Version 1.0	February 2002	All	New Format	EDS Publications
Version 2.0	July 2002	All	Second Quarter 2002 Update	EDS Client Services Department
Version 3.0	December 2003	All	Fourth Quarter 2003 Update	EDS Client Services Department

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Section 1: Introduction

Overview

The information in this supplemental provider manual is specifically for Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) services provided to Indiana Health Coverage Programs (IHCP) members younger than 21 years old. In Indiana, the federally mandated EPSDT Program is referred to as the HealthWatch Program. Providers currently enrolled in the IHCP can provide appropriate EPSDT services to enrolled members. Specific rules about HealthWatch services can be found in *405 IAC 5-15* (also located in *Appendix A of the IHCP Provider Manual)*. Details provided in the applicable Indiana administrative code rules are not repeated in this manual except to clarify or to expand on procedural issues.

The *IHCP Provider Manual* contains detailed information about billing for services on a medical claim form. However, billing requirements for EPSDT services are outlined in this supplemental provider manual. The areas addressed in this manual include:

- Hoosier Healthwise and *Medicaid Select* Considerations
- HealthWatch Screening Examinations
- Screen Components
- Documentation
- Billing Information
  - Reimbursement
  - Periodicity and Immunization Schedule
  - HealthWatch/EPSDT Codes
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- Indiana's First Steps Program
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- Drug Testing
- Lead Screening
- Newborn Screening
- Sickle Cell Anemia
- Iron Deficiency Anemia
- Tuberculosis

Section 2: Contacts for More Information

Table 2.1 – Contact Information

Name	Contact Information
EDS Adjustments	**EDS Adjustments** **P.O. Box 7265** **Indianapolis, IN 46207-7265**
AVR System **EDS Automated Voice Response**	**(317) 692-0819** in the Indianapolis local area or **1-800-738-6770** Seven days per week, 24 hours per day
EDS Customer Assistance	**(317) 655-3240** in the Indianapolis local area or **1-800-577-1278** 8 a.m. to 5:30 p.m. (EST – Indianapolis local time) Monday through Friday (except holidays) The toll free number is available to providers located throughout Indiana, Michigan, Ohio, Kentucky, and Illinois.
EDS Electronic Solutions Help Desk	**(317) 488-5160** 8 a.m. to 5 p.m. (EST – Indianapolis local time) Monday through Friday (except holidays) E-mail: electronic.solutions@indyxix.eds.com
EDS Forms Request	**EDS Forms Request** **P. O. Box 7263** **Indianapolis, IN 46207-7263** Forms are available on line at www.indianamedicaid.com
EDS HealthWatch Claims	**EDS Medical Claims** **P.O. Box 7269** **Indianapolis, IN 46207-7269**
EDS Member Hotline	**(317) 713-9627** in the Indianapolis local area or **1-800-457-4584** 8 a.m. to 5 p.m. (EST – Indianapolis local time) Monday through Friday (except holidays) The toll-free number is available in Indiana, Michigan, Ohio, Kentucky, and Illinois.
EDS OMNI Help Desk	**1-800-284-3548** 8 a.m. to 5 p.m. (EST – Indianapolis local time) Monday through Friday (except holidays)
ACS Pharmacy Benefit Management Call Center for Pharmacy Services POS/ProDUR	**1-866-645-8344** E-mail: Indiana.ProviderRelations@acs-inc.com
EDS Provider Enrollment	**1-877-707-5750** 8 a.m. to 5 p.m. (EST – Indianapolis local time) Monday through Friday (except holidays) **EDS Provider Enrollment** **P.O. Box 7263** **Indianapolis, IN 46207-7263**
EDS Provider Written Correspondence	**EDS Provider Written Correspondence** **P.O. Box 7263** **Indianapolis, IN 46207-7263**

(Continued)

Table 2.1 – Contact Information

Name	Contact Information
EDS Third Party Liability (TPL)	**(317) 488-5046** in the Indianapolis local area or **1-800-457-4510** **Fax: (317) 488-5217** 8 a.m. to 5:30 p.m. (EST – Indianapolis local time) Monday through Friday (except holidays)
First Steps	**1-800-441-STEP**
Health Care Excel Medical Policy Department	**(317) 347-4500** 8 a.m. to 5 p.m. (EST – Indianapolis local time) Monday through Friday (except holidays) **Health Care Excel** **Medical Policy Department** **P.O. Box 53380** **Indianapolis, IN 46253-0380**
Health Care Excel Prior Authorization (PA) (including RBMC carve out services)	**(317) 347-4511** in the Indianapolis local area or **1-800-457-4518** 7:30 a.m. to 6 p.m. (EST – Indianapolis local time) Monday through Friday (except holidays) **Health Care Excel** **Prior Authorization Department** **P. O. Box 531520** **Indianapolis, IN 46253-1520** *To receive 1261A forms contact:* **Forms Distribution Center** **6400 East 30th Street** **Indianapolis, IN 46219** **(317) 591-5228**
Health Care Excel Provider and Member Concern Line (Fraud and Abuse)	**(317) 347-4527** in the Indianapolis local area or **1-800-457-4515** 8 a.m. to 5 p.m. (EST – Indianapolis local time) Monday through Friday (except holidays)
Health Care Excel Surveillance and Utilization Review (SUR)	**(317) 347-4527** in the Indianapolis local area or **1-800-457-4515** 8 a.m. to 5 p.m. (EST – Indianapolis local time) Monday through Friday (except holidays) **Health Care Excel** **Surveillance and Utilization Review** **P.O. Box 531700** **Indianapolis, IN 46253-1700**
Indiana Health Coverage Programs Web Site	**www.indianamedicaid.com**
Harmony Health Plan **(Northern region of the State)**	**Provider Services** **1-800-504-2766** **Claims** **1-800-504-2766** **Prior Authorization** **1-800-504-2766** **Member Services** **1-800-608-8158** **TTY: 1-877-650-0952**

(Continued)

Table 2.1 – Contact Information

Name	Contact Information
Managed Health Services (MHS) **(Statewide)**	**Provider Services*** **1-800-414-9475** **Claims*** **1-800-414-9475** **Prior Authorization/Medical Management** **1-800-464-0991** **Member Services** **1-800-414-5946** ***For dates of service prior to January 1, 2001, for MaxiHealth Northern and Southern region members: **Provider Services and Claims: 1-800-414-9475** *For dates of service prior to January 1, 2001, for CIMCO members: **Provider Services and Claims: 1-800-356-1204** **or** **(317) 630-2831**
Mdwise **(Statewide)**	**Provider Services** **1-800-356-1204** **or** **(317) 630-2831** **Claims** **1-800-356-1204 or (317) 630-2831** **Prior Authorization/Medical Management** **1-800-356-1204** **or** **(317) 630-2831** **Member Services** **1-800-356-1204** **or** **(317) 630-2831**
Prime*Step* (AmeriChoice) **(Statewide)**	**Provider Services** **1-800-889-9949 Option 3** **Claims** **Automated Voice Response: 1-800-738-6770** **Or** **(317) 692-0819** **EDS Customer Assistance: 1-800-577-1278** **or** **(317) 655-3240** **Prior Authorization** **Health Care Excel: 1-800-457-4518** **or** **(317) 347-4511** **Member Services** **1-800-889-9949 Option 1**

(Continued)

Table 2.1 – Contact Information

Name	Contact Information
Medicaid Select **(AmeriChoice)** **(Statewide)**	**Provider Services** **1-877-633-7353 Option 3** **Claims** **Automated Voice Response: 1-800-738-6770** **Or** **(317) 692-0819** **EDS Customer Assistance: 1-800-577-1278** **or** **(317) 655-3240** **Prior Authorization** **Health Care Excel: 1-800-457-4518** **or** **(317) 347-4511** **Member Services** **1-877-633-7353 Option 1**

Section 3: HealthWatch /EPSDT Information

Introduction

The EPSDT Program, referred to as HealthWatch in Indiana, is a preventive health care program designed to improve the overall health of eligible infants, children, and adolescents. Special emphasis is given to **early detection** and treatment because these efforts can reduce the risk of more costly treatment or hospitalization that can result when detection is delayed. HealthWatch services are available to IHCP members from birth to 21 years old (subject to the limitations of each benefit package). Individuals enrolled in Hoosier Healthwise Package C are eligible for these services; however, treatment may be subject to benefit limitations. EPSDT is a required component of care for Hoosier Healthwise managed care members.

Staff at the 92 county offices of the Division of Family and Children (DFC) are responsible for HealthWatch program outreach and for informing IHCP-eligible individuals about the availability of HealthWatch services. County offices of the DFC and the Indiana Family Help Line also provide assistance to individuals who need help scheduling appointments and making transportation arrangements to HealthWatch services. Hoosier Healthwise Prime*Step* and *Medicaid Select* primary care case management participants should contact AmeriChoice member services for assistance with appointment scheduling and arranging transportation. Risk-based managed care (RBMC) participants must consult their managed care organization (MCO) for assistance with appointment scheduling and arranging transportation.

Notices reminding individuals they may be due for a HealthWatch screen are routinely mailed to HealthWatch participants in the month prior to their birthday. These notices include instructions that individuals should contact their doctors to determine when they are due for a checkup.

> *Note: EPSDT services may be subject to benefit limitations. The* IHCP Provider Manual *gives more detailed information about limitations.*

Hoosier Healthwise

During the summer of 1994, Indiana's Office of Medicaid Policy and Planning (OMPP) began implementing a mandatory managed care program called Hoosier Healthwise. The goals of the managed care program are to:

- Ensure access to primary and preventive care services
- Improve access to all necessary health care services
- Encourage quality, continuity, and appropriateness of medical care
- Provide medical coverage in a cost-effective manner

Hoosier Healthwise no longer refers exclusively to managed care. In 1999, this term was broadened to include coverage for children, pregnant women, and families that meet certain income guidelines. The majority are enrolled in managed care; however, a few are enrolled in the fee-for-service delivery system. For example, a ward or foster child may be in either managed care (on a voluntary basis) or the fee-for-service delivery system. Children receiving waiver services should not be enrolled in managed care.

Additionally, the term *Hoosier Healthwise* is now more broadly defined to include not only the various managed care delivery systems, but also the other benefit packages identified in Table 3.1. The table also lists the associated coverage.

Table 3.1 – Hoosier Healthwise Benefit Packages

Benefit Package	Coverage
Package A – Standard plan	Full coverage
Package B – Pregnancy Coverage	Pregnancy related and urgent care services only
Package C – Children's Health Plan	Preventive, primary and acute care service for children younger than 19 years old
Package D	Open for future use
Package E – Emergency Services	Emergency services, including labor and delivery until the mother is stable

Program Structure

The Hoosier Healthwise Program is comprised of the following three delivery systems:

- Fee-for-service (FFS)
- Primary Care Case Management (PCCM)
- Risk-based managed care (RBMC)

Most eligible members of packages A, B, and C have a primary medical provider (PMP) and are enrolled in either the PCCM or RBMC delivery system. Members who enroll with a PMP in the RBMC network also will be enrolled with an MCO that will coordinate most medical services. Members enrolled in Hoosier Healthwise Package E will not be linked to a PMP and will remain in FFS.

If a member who is eligible for package A, B, or C fails to make a PMP selection within 30 days of being determined or redetermined eligible, a PMP is assigned to the member through the auto-assignment process.

For purposes of Hoosier Healthwise Managed Care Program administration, Indiana is divided into the following three regions:

- Northern
- Central
- Statewide

The State contracts with MCOs to provide services in one, two, or all three regions of the State. PCCM, under the name Prime*Step*, is administered by AmeriChoice for the State in all three regions.

The Centers for Medicare and Medicaid Services (CMS) have approved mandatory Hoosier Healthwise MCO enrollment in the following counties:

- Allen and Marion counties, effective April 1, 2002
- Elkhart and St. Joseph counties, effective July 1, 2002
- Lake county, effective October 1, 2002
- Porter and LaPorte counties, effective November 1, 2003

Contracted MCOs assume financial risk for developing and managing a health care network that arranges for or provides Hoosier Healthwise covered services. The State pays the MCO a monthly capitation fee for each enrolled member. MCOs submit shadow claims to EDS using claim data.

A physician or other health care provider that is interested in joining the RBMC provider network should contact the MCO(s) serving that region.

For dates of service in calendar year 2001, claims should be sent to the member's managed care entity at that time.

In addition to Prime*Step* PCCM, the MCOs are:

- Harmony Health Plan (northern and central regions)
- MDwise (statewide)
- Managed Health Services (MHS) (statewide)

> *Note: MaxiHealth served as an MCO statewide until it ceased business operations May 31, 2001. For MaxiHealth claims with dates of service between January 1, 2001, and May 31, 2001, providers should contact Indiana Insolvency, Inc., at 1-800-441-3355.*

Medicaid Select

The 2002 General Assembly passed a law that required the OMPP to amend the State's waiver under *42 U.S.C 139n(b)(1*) to include the aged, blind, and disabled in the managed care program under *Indiana Code (IC) 12-15-12*. The waiver amendment was approved November 22, 2002.

Individuals who are eligible for the new *Medicaid Select* program include children receiving adoptive services, aged, blind, disabled, Medicare-IHCP dual eligibles, and individuals receiving room and board assistance. The program is mandatory for these enrollees. Persons in nursing homes and other institutions, such as Intermediate Care Facilities for the Mentally Retarded (ICFs/MR), members with spend-down, and members enrolled in waiver or hospice services will not be enrolled in *Medicaid Select*.

In 2003, *Medicaid Select* was phased in under a PCCM model (fee-for-service plus an administrative fee payment to physicians). In the future, the OMPP plans to procure risk-based managed care organizations (in a per member, per month capitated model) in addition to the PCCM delivery system.

Medicaid Select has five standard PMP categories – family practitioner, general practitioner, internist, pediatrician, and obstetrician/gynecologist (OB/GYN). Specialists can also enroll as PMPs. Enrollees have 60 days to self-select a PMP. If the enrollee does not select a PMP within 60 days, a PMP is automatically assigned to the member. Members are only automatically assigned to one of the five standard PMP provider types. Members are only linked to specialists if they are self-selected or the provider is a previous PMP based on the member's history. Members can always change a PMP, if necessary.

Primary Medical Providers

Physicians enrolled in the IHCP as Hoosier Healthwise or *Medicaid Select* PMPs, provide preventive and primary medical care through an ongoing member-to-PMP relationship, as well as authorization and referral for most medically necessary specialty services.

The PMP or designee must be available 24 hours a day, seven days a week, and must assume management of the member's health and medical needs.

A Hoosier Healthwise PMP must be a physician in general practice, or specialize in family practice (provider type 31, specialty 316), general pediatrics (provider type 31, specialty 344), general internal medicine(provider type 31, specialty 345), or Obstetrics/Gynecology (OB/GYN) (provider type 31, specialty 328). Primary care physicians in any setting are eligible to be PMPs and can serve as the PMP for any member within their normal scope of practice. In *Medicaid Select*, specialists may also serve as PMPs.

Physicians enrolled in Hoosier Healthwise with dual specialties in internal medicine and pediatrics may also enroll as PMPs upon submitting documentation of training in both specialties. Physicians who enroll agree to be listed as PMPs in the Hoosier Healthwise provider listing.

Physicians interested in becoming PMPs have the opportunity to contact one of the MCOs or AmeriChoice for additional information. When physicians decide to enroll as a PMP, they are required to sign either a contract addendum to the IHCP Provider Agreement to enroll in the PCCM network, or a contract with an MCO to participate in the RBMC network.

Physicians are permitted to act as PMPs in both PCCM and RBMC simultaneously, but the process of accepting new patients is limited to one delivery system at a time. In other words, PMPs participating in both PCCM and RBMC must designate under which delivery system they wish to receive new patients and this selection must be maintained for at least one calendar quarter. Existing patients can remain under the MCE in which they were originally enrolled (PCCM or RBMC) regardless of the delivery system in which the PMP is currently accepting new patients.

IHCP providers not enrolled as Hoosier Healthwise PMPs, either through choice or because they are not eligible to enroll as a PMP, may continue to provide necessary health and medical care to members who are enrolled in the FFS delivery system. These providers may also provide services to Hoosier Healthwise or *Medicaid Select* members enrolled in PCCM or RBMC after receiving a referral or authorization from the member's PMP unless it is a self-referral or carve-out service (no PMP referral is required for self-referral or carve-out services).

Service Provision

PMPs are expected to either personally provide or authorize most primary and preventive care services as a case management function. All PMP referrals or authorizations must be documented in the patient's medical record. For those medical services that do not require PMP authorization, members may gain access through self-referral or PMPs may assist members in accessing services by providing information on specialists or other available resources.

The PMP is responsible for providing or authorizing most primary and preventive care services. These services, called PMP services, include but are not limited to the following:

- Physician services
- Hospital inpatient and outpatient services
- Some ancillary services

> *Note: PMPs furnishing services to Hoosier Healthwise or* Medicaid Select *members in either the PCCM or RBMC delivery systems are required to participate in the HealthWatch/EPSDT program.*

PMPs are not required to provide or authorize the following *self-referral services*:

- Services for the treatment of a true medical emergency
- Behavioral health furnished by a provider enrolled with a behavioral health type and specialty
- Family planning services, using the appropriate diagnosis and procedure code combinations
- Dental services by a provider enrolled with a dental type and specialty
- Chiropractic services
- Podiatry services
- Vision care services (except surgical services)
- HIV/AIDS targeted case management services
- Transportation services
- Pharmacy services
- Individualized Education Plan (IEP) services furnished by schools

Self-referral services and other PMP-authorized services are to be billed to the appropriate delivery system (EDS for Prime*Step* or FFS and the MCOs for RBMC) with the exception of **the following services that are always billed to and paid by EDS in accordance with IHCP regulations:**

- Behavioral health, including mental health and substance abuse and chemical dependency services, rendered by providers enrolled in the IHCP with a mental health specialty
- Dental services rendered by providers enrolled in the IHCP in a dental specialty. The dental specialties are the following:
  - Dental clinic
  - Endodontist
  - General dentistry practitioner
  - Mobile Dentist Oral surgeon
  - Orthodontist
  - Pediatric dentist
  - Periodontist
  - Prosthodontist
- Services provided by a school as part of a student's individualized education plan (IEP)

Program Financing

Under Prime*Step* PCCM, PMPs assume no financial risk and receive an administration fee per month for every enrolled member. Reimbursement for services provided to Prime*Step* PCCM members follows the standard IHCP fee schedules, and providers rendering services to Prime*Step* PCCM-enrolled members should continue to bill the IHCP.

Under RBMC, PMPs negotiate reimbursement with the contracted MCO. Most claims for members enrolled in the RBMC delivery system must be submitted to the member's MCO. Claims submitted to the IHCP for services covered under the MCO capitation are denied by the IHCP. (Dental services submitted on the dental claim form and mental health services by mental health provider type and specialty and school corporation services are carved out from managed care and subject to IHCP guidelines.) For this reason, all providers must verify member eligibility and PMP assignment prior to rendering services.

PMP Authorization and Prior Authorization

All PMP services not provided by the member's PMP must be referred or authorized by the PMP in Prime*Step* PCCM through the use of a certification code. This is different from prior authorization (PA) by the health plan network, which may be required for some PMP and self-referral services. Prime*Step* PCCM PA is obtained from Health Care Excel (HCE). PMP referral, authorization, and PA for services may follow different requirements in RBMC. Please contact the appropriate MCO for instructions for PMP referral, authorization and PA. RBMC carve out services may require PA.

A referral is a request for PMP-approved services from another provider. The PMP specifies which services are covered with this referral. The referral must be documented in the patient's medical record. However, no referral forms are required. In some instances, patients can refer themselves without a PMP authorization. The following services do not require PMP authorization:

- Ancillary services (radiology, pathology, laboratory, and anesthesia)
- Behavioral health by type and specialty
- Chiropractic
- Dental care by specialty (except surgeries)
- Durable medical equipment and supplies
- Family planning (using appropriate diagnosis and procedure code combinations)
- HIV/AIDS case management
- Home health services
- Individualized education plan (IEP) services furnished by schools
- Outpatient therapy services (physical, occupational, respiratory, and speech)
- Pharmacy services
- Podiatric services
- Services for treatment of a true emergency
- Transportation
- Vision care by specialty (except surgeries)

To comply with IHCP PA requirements to complete PA requests for members in the PCCM delivery system according to IHCP policies, the listed services do not require PMP authorization. Providers rendering care to RBMC-enrolled members should refer to the member's MCO for any additional policies specific to that RBMC network.

For More Information About Managed Care Networks

For more information about the Hoosier Healthwise Prime*Step* PCCM managed care delivery system, please call the Hoosier Healthwise Helpline at 1-800-889-9949. This helpline is available to answer provider and member questions about the Hoosier Healthwise managed care program.

For more information about the *Medicaid Select* PCCM managed care delivery system, contact the *Medicaid Select* Helpline at 1-877-633-7353. The helpline is available to answer provider and member questions about the *Medicaid Select* managed care program.

For information about the Hoosier Healthwise RBMC plans, please call the MCO available in your region.

Non-Managed Care Members

If a member is not enrolled in either Prime*Step* PCCM or RBMC delivery system, any IHCP provider can provide services.

Any provider enrolled in the IHCP, licensed to perform an unclothed physical exam and provide the components listed in the *Screen Components* subsection of this manual, is eligible to offer HealthWatch screens for infants, children, and adolescents. There is no requirement that an IHCP provider that is not a managed care PCCM or RBMC PMP must accept new patients. Providers can choose to offer screens to only those IHCP patients assigned to their practice or currently being seen in their office.

Providers must assist in setting appointments on behalf of HealthWatch participants that need diagnostic services or follow-up treatment as a result of the screen. These additional services require PMP authorization when performed by a provider other than the PMP.

If assistance is needed to locate a specialist enrolled in the IHCP for referral purposes, contact the Indiana Family Helpline at the Indiana State Department of Health at 1-800-433-0746.

HealthWatch Screening Examinations

Ensuring that all children in the IHCP receive age-appropriate, comprehensive, preventive services is the primary goal of the HealthWatch/EPSDT program. Components of the screen and the recommended frequency of the screens are listed in the *HealthWatch Periodicity and Screening Schedule* found in *Appendix A.* The periodicity schedule follows guidelines set by the American Academy of Pediatrics (AAP), and contains footnotes to clarify screening components. Additional information concerning risk factors is included in this manual.

Screening Components and Higher Reimbursement

According to *405 IAC 5-15-2*, a screening, or any portion of a screening is not required when lack of medical necessity is documented. To provide quality assurance for participants in the HealthWatch program and claim a higher level of reimbursement for EPSDT screens, the following components of the screen must be **provided and documented**:

- A health and developmental history, including assessment of both physical and mental health development
- An unclothed physical exam
- A nutritional assessment
- A developmental assessment
- Vision observation at each screen and direct referral to an optometrist or ophthalmologist starting when objective screen methods indicate a referral is warranted
- Hearing observation at each screen and objective testing with audiometer at four years, administered or referred

- Dental observation at each screen; direct referral to a dentist starting at 24 months old. Dental referrals may be made as early as 12 months old when indicated.
- Laboratory tests, including blood lead level assessment appropriate for age and risk factors
- Immunizations administered or referred, if needed at time of the screen
- Health education, including anticipatory guidance

For further information on billing guidelines for receiving higher reimbursement, please see *Examination Procedure and Diagnosis Codes* and *Reimbursement* in this section.

Documentation

Documentation for the HealthWatch screen may be incorporated into the documentation routinely kept for well child check-ups. However, when the patient receives HealthWatch screen components or when the patient is referred elsewhere to receive components, it is imperative that the patient record reflects the components that were given and also the components, if any, that were referred elsewhere. If a child needs more frequent screening than recommended by the periodicity schedule, interperiodic screens may be performed. Interperiodic office visits and EPSDT screening exams are covered by the IHCP up to the 30-office visit maximum per individual, per year. Please review *Chapter 2* and *Chapter 8* of the *IHCP Provider Manual* for information about billing non-EPSDT office visits and the office visit benefit limitation. Additional office visits that are not full HealthWatch EPSDT screens should not be billed using the primary diagnosis code of V20.2. These office visits should be billed with the appropriate Evaluation and Management (E/M) procedure codes to receive correct reimbursement.

Each physician has unique preferences for methods of documentation in patient charts. In response to requests from HealthWatch participating providers, the following examples indicate some tools available for physician's use in simplifying documentation of EPSDT screen components in medical records.

Bright Futures

Bright Futures Project
2000 15th Street North
Suite 701
Arlington, VA 22201-2617

Telephone: (703) 524-7802
Fax: (703) 524-9335
E-mail: brightfutures@ncemch.org
Web site: www.brightfutures.org

Pfizer, one of the corporate sponsors of Bright Futures, will provide free copies of the following Bright Futures material (call 1-800-733-2323):

- Pocket guide to encounter
- Growth chart
- Activity book (coloring book for children)
- Encounter Form for Health Professionals (Guidelines for Health Supervision of Infants, Children, and Adolescents)

Indiana State Department of Health

The ISDH has designed *Recommendations for Preventative Pediatric Health Care* for the care of children who are receiving competent parenting, have no manifestations of any major health problems, and are growing and developing in satisfactory fashion. These guidelines represent a consensus by the Committee of Practice and Ambulatory Medicine in consultations with the national committees and sections of the AAP. For more information contact:

Maternal and Child Health Services
Indiana State Department of Health
2 North Meridian Street, Section 7C
Indianapolis, IN 46204

Telephone: 1-800-433-0746
Fax: (317) 233-1299

American Academy of Pediatrics

Form: *Guidelines for Health Supervision*
Telephone: 1-800-433-9016
Web Site: www.aap.org

Center for Disease Control, National Center for Health Statistics

A detailed medical growth chart designed for each age group is available from the Center for Disease Controls (CDCs) National Center for Health Statistics. The CDC can be contacted in one of the following ways:

National Center for Health Services (NCHS)
Division of Data Services
6525 Belcrest Road
Hyattsville, MD 20782-2003

Telephone: (301) 458-4636
Web Site: www.cdc.gov/growthcharts

Providers are also encouraged to periodically check the CDC/NCHS Web page at www.cdc.gov/nchs for announcements and updates about distribution and training materials.

General Billing Information

Indiana does not require providers to bill EPSDT screens on a separate EPSDT claim form; however, HealthWatch providers must adhere to EPSDT billing and screening procedures to participate in this program. To claim the higher rate of reimbursement for EPSDT screens, HealthWatch providers must furnish all components of the EPSDT in accordance with the EPSDT Periodicity and Screening Schedule (see *Appendix A*), document services performed/referred, and include all applicable diagnosis codes (as many as four for paper claims or as many as eight on the 837P/electronic claim submission; however only the first four will be used for processing) on the claim for each EPSDT screening exam. To ensure adherence to EPSDT requirements, the IHCP will monitor the following:

- Timely screening as recommended by the *HealthWatch/EPSDT Periodicity and Screening Schedule* and the immunization schedule in Appendix A

- Timely administration of immunizations
- Hematocrit/hemoglobin testing
- Blood lead testing
- Urinalysis
- Audiometry testing
- Children receiving treatment for diagnosed conditions

Specific Billing Procedures

The following billing procedures must be followed to permit correct and prompt reimbursement. HealthWatch claims are billed on a professional medical claim form. A computer-generated sample CMS-1500 claim form currently used for medical claims is provided in *Appendix D* for reference**.**

> *Note: The CMS-1500 was formerly known as the HCFA-1500 claim form. The IHCP accepts claim forms labeled as either HCFA-1500 or CMS-1500*

Every claim for a HealthWatch/EPSDT visit must be coded with the following:

- The appropriate patient examination code (99381-99385, 99391-99395) must be included on the first detail line of the medical claim form
- The preventive health diagnosis code, V20.2, as the **primary** diagnosis
- **Physicians are strongly encouraged to include all applicable diagnosis codes (as many as four for paper claims or as many as eight on the 837P/electronic claim submission; however only the first four will be used for processing) and procedure codes on the claim for each HealthWatch/EPSDT visit.**

The appropriate EPSDT documentation should be kept in the patient's record and the reimbursement rate for the initial or established patient exam should be billed.

> *Note: When patient exams are billed in conjunction with the V20.2 diagnosis code as the primary diagnosis code, the screen components must be provided. Examples of the most frequently occurring diagnoses among HealthWatch/EPSDT patients are listed in Appendix B.*

Examination Procedure and Diagnosis Codes

Providers are required to use specific examination codes, classified as initial or established, based on the age of the member. **Providers are strongly encouraged to include all appropriate codes and to use the preventive health diagnosis code V20.2 as the *primary* diagnosis code when a HealthWatch screen is billed**. The primary diagnosis code (V20.2) must be indicated with the diagnosis cross-reference code of **1** in box 24 E of the medical claim form for the procedure code billed. The procedure codes are shown in Table 3.2.

Table 3.2 – Procedure Codes

Age	Initial Patient Exam	Established Patient Exam
Less than one year	99381	99391
One to four years	99382	99392
Five to 11 years	99383	99393
12 to 17 years	99384	99394
18 to 20 years	99385	99395

Any other applicable diagnosis code(s) should be indicated in the second, third, or fourth position in item 21 on the paper medical claim form and cross-referenced accordingly in item 24E.

Reimbursement

Reimbursement for the initial patient exam is limited to the first HealthWatch/EPSDT screen performed by a screening provider during the participant's lifetime. If additional claims are received for initial screening from the same provider, reimbursement is allowed at the Resourced-Based Relative Value Scale (RBRVS) rate on file for the billed current procedural terminology (CPT) code, not the higher EPSDT rate. EPSDT exams are reimbursed as in Table 3.3 when submitted with V20.2 as the primary diagnosis, but are subject to the 30 office visits per year limitation without PA. **Claims submitted with charges other than the designated amounts for screening exams are paid at the HealthWatch/EPSDT rate or the charged amount, whichever is lower**. Visits that do not contain the screening components or that are not well child visits can be billed using the appropriate CPT code for those visits. If the preventive E&M codes are used, V20.2 should not be used as the primary diagnosis.

Table 3.3 – EPSDT Reimbursement Rates

Rate	Type	Proc. Code	Dx Code
$50	Initial patient exam	99381-99385	V20.2
$37	Established patient exam	99391-99395	V20.2

Periodicity and Immunization Schedule

When any one of the above patient exams is billed in conjunction with the V20.2 diagnosis code as the primary diagnoses code, the screening components must have been provided. Appropriate documentation of the services provided or referred must be included in the patient's medical records. The *HealthWatch Periodicity and Immunization Schedules* are found in *Appendix A.*

The *Catch-up Immunization Schedule* for children who are identified as non-immunized at ages older than the ages identified in the *Periodicity and Immunization Schedule* is found in *Appendix B.*

Immunization and Screen Billing Procedures

Providers must report on the claim form all screens and immunizations administered during HealthWatch/EPSDT visits. Providers should follow the *HealthWatch/EPSDT Periodicity and*

Screening Schedule (see *Appendix A)* and provide or arrange for all the appropriate services for each child at each age level in a timely manner and complete the claim form properly. The IHCP will closely monitor all claims submitted to ensure that appropriate procedures are provided and to give the provider feedback concerning age-specific HealthWatch/EPSDT service delivery.

HealthWatch/EPSDT Codes

Appendix B includes a summary of routinely used HealthWatch/EPSDT codes.

Third Party Liability

Federal regulations allow for the bypass of third party liability (TPL) claim edits when HealthWatch/EPSDT screening procedures are submitted for payment. The CPT procedure codes identified in this section and in *Appendix B* are routinely billed for HealthWatch/EPSDT services. **These codes are not subject to TPL edits when submitted in conjunction with the primary diagnosis code V20.2.**

Prior Authorization

For information about services that require IHCP prior authorization, please consult the IHCP's Covered Services and Limitations Rule *405 Indiana Administrative Code (IAC) 5* and *Chapter 6* of the *IHCP Provider Manual*.

Vaccines for Children

The Federal Vaccines For Children (VFC) program makes available at no cost to providers certain vaccines for administration to IHCP-members ages 18 years old and younger (including those 18 and under enrolled in Package C). Effective July 1, 1998, IHCP **reimbursement for vaccines available through the VFC program is limited to the VFC vaccine administration fee**. As of May 1, 1998, the VFC vaccine administration fee is a maximum of $8 (payment is made at the lower of $8 or submitted charge).

The VFC Program supplies health care providers with free vaccines to be administered to children 18 years old and younger who meet one or more of the following:

- Enrolled in Medicaid
- No health insurance
- An American Indian or Alaskan native, as identified by the parent or guardian
- Underinsured, for example, the child has health insurance that does not cover immunizations

Underinsured patients are eligible to receive VFC vaccines only at a federally qualified health center or rural health clinic.

The VFC Program is for uninsured children. Hoosier Healthwise Package C is considered an insurance program. The OMPP, the Children's Health Insurance Program (CHIP), and the ISDH have worked to open the VFC Program to all children in Medicaid, *Medicaid Select*, and the Hoosier Healthwise benefit packages, including Hoosier Healthwise Package C.

Currently the VFC program offers free vaccines against the following diseases:

- Diphtheria

- Hemophilus influenza type B
- Hepatitis B
- Influenza
- Measles
- Mumps
- Rubella
- Pertussis
- Poliomyelitis
- Tetanus
- Varicella
- Pneumoccocal disease (effective January 1, 2001)

IHCP providers are encouraged to participate in the VFC Program. If a provider chooses not to participate in the VFC Program, the practitioner must provide appropriate vaccine referrals, follow up with the patient, and document the immunization history. If a Hoosier Healthwise PMP does not choose to participate in the VFC Program, the provider must have a procedure in place, such as a memorandum of collaboration (MOC), to ensure that children under his or her care are adequately and appropriately immunized.

General VFC Billing Information

Effective July 1, 1998, IHCP fee-for-service reimbursement for any vaccine available through the VFC Program is limited to the lesser of the submitted charge or the current VFC administration fee, when the vaccine is administered to an IHCP member 18 years or younger.

> *Note: For vaccines **not** available through the VFC and for vaccines administered to IHCP members older than 18 years old, the IHCP reimbursement for the immunization procedure code includes payment for the vaccine plus $2.90 for administration. Please see* Billing Non-VFC Immunizations *in this section for more information.*

For details about reimbursement under the RBMC delivery system, please call the appropriate MCO. For questions on collaborative agreements for vaccine referrals to health departments or nurse clinics, contact the Hoosier Healthwise Helpline at 1-800-889-9949, select option 3. For *Medicaid Select*, contact provider services at 1-877-633-7353, option 3.

To bill the IHCP for VFC vaccine administration use **V20.2** as the primary diagnosis and the correct procedure code for the specific vaccine administered (do not bill the code for administration) and claim no more than the VFC vaccine administration fee in effect on the date of service. For dates of service from May 1, 1998, forward, the Medicaid maximum allowable reimbursement for VFC vaccine administration is $8. The IHCP permits only one administration fee per VFC vaccine administration. For combined vaccines, bill the correct code for the combined vaccine and charge only one vaccine administration fee. If the only service performed is vaccine administration, providers cannot bill for an office visit. Providers can bill an office visit in conjunction with vaccine administration only when a significant, separately identifiable service is performed at the same visit.

Table 3.4 – Procedure Codes For VFC-Available Vaccines

Procedure Code	Vaccines
90645	Hib, HBOC
90647	Hib, PRP-OMP
90648	Hib, PRP-T
90669	Pneumoccocal conjugate, polyvalent
90700	DTaP
90702	DT
90707	MMR
90713	Inactivated Polio Vaccine (EIPV)
90716	Varicella
90718	Td
90721	DTaP-Hib
90723	DTap-Hep B-IPV, brand name Pedirix
90657	Influenza, split virus, 6-35 months dosage
90658	Influenza, split virus, three years and older
90744	HEP B-Ped
90745	HEP B-Adolescent
90748	HEP B-Ped-Hib combination, brand name Comvax

Contact the ISDH to enroll in the VFC Program. To participate in the VFC Program:

- Call the ISDH office at (317) 233-7704 or 1-800-701-0704 and request VFC provider enrollment forms.
- Complete and mail the provider enrollment forms.
- Receive appropriate training and technical assistance.
- Order vaccine periodically, as needed, and maintain appropriate vaccine supply records.

Vaccines for Children Forms

The patient eligibility screening record that many providers use to screen patients for VFC eligibility has been revised to include a box to indicate Hoosier Healthwise Package C eligible children. As with the VFC Program, providers may use this form for screening or incorporate it into existing clinic forms.

Providers may continue to use the same vaccine order form to order vaccines. Because vaccines are provided by different funding sources, the ISDH must report the number of doses administered to children on the VFC Program and children enrolled in Hoosier Healthwise Package C separately. The *Patient Eligibility Screening Record* and the *Vaccine Accountability Tally Sheet* have been revised to incorporate vaccines administered to children enrolled in Hoosier Healthwise Package C.

Providers no longer need to submit the *Vaccine Accountability Tally Sheet* when ordering vaccines. Instead, this form should be submitted to the ISDH monthly, by the tenth of the month following the month in which vaccines were administered. This change standardizes the reporting timeframe for all providers.

Send forms to the following address:

Indiana Immunization Program
Indiana State Department of Health
2 North Meridian Street
Indianapolis, IN 46204

The telephone numbers are (317) 233-7704 in the Indianapolis local area and 1-800-701-0704.

Hoosier Healthwise Package C and Vaccine Storage

Providers are not required to physically separate vaccine stock for children in the VFC Program from vaccine stock for Hoosier Healthwise Package C children. No additional rules are necessary.

Contact Information

Direct questions concerning VFC provider enrollment, patient eligibility for VFC, and vaccine orders and distribution, to the ISDH at:

Indiana Immunization Program
Indiana State Department of Health
2 North Meridian Street
Indianapolis, IN 46204
Phone (317) 233-7704 or 1-800-701-0704
Fax (317) 233-3719

Contact EDS Customer Assistance at (317) 655-3240 in the Indianapolis local area or 1-800-577-1278 with questions about IHCP fee-for-service billing and reimbursement for VFC vaccines. Contact the patient's MCO with questions about VFC vaccine administration and reimbursement under the Hoosier Healthwise RBMC network.

Vaccine Stock Availability

On occasion, the VFC codes may be temporarily removed from the table if they are not available and at that time, all non-VFC billing guidelines apply. When a specific vaccine becomes available again, it is added to the table with the appropriate start date. Banner page articles provide information about vaccine stock availability.

Third Party Liability

Vaccines administered to VFC-eligible children can be billed directly to the appropriate delivery system (EDS or the MCO) when the primary diagnosis is V20.2. These vaccines do not need to be billed to the primary insurance company. Providers should not experience third party liability (TPL) issues with children enrolled in Hoosier Healthwise Package C. If information identifies a primary insurance for a child enrolled in Hoosier Healthwise Package C, contact the EDS TPL Unit at (317) 488-5046 in the Indianapolis local area or 1-800-457-4510.

Billing Vaccines Other Than VFC

For vaccines not available through the VFC program, and for vaccines administered to patients older than 18 years old, the IHCP calculates the maximum allowable reimbursement based on the current

average wholesale price (AWP) for the procedure code, plus $2.90 for vaccine administration to cover the costs of supplies and staff time associated with giving the injection. The IHCP maximum allowable amount corresponds to the dose in the narrative description for the procedure code. In cases where there is no dose specified in the narrative, the reimbursement rate is set by the contractor that is responsible for updating the rates based on what corresponds to a typical dose for that particular code. Providers are notified through bulletin or remittance advice banner page articles about reimbursement rates for codes with no dose specified.

> *Note: New injectable drugs covered under the IHCP that cannot be billed with an existing CPT or Health Care Common Procedure Coding System (HCPCS) code because there has not been a specific code assigned, should be billed using an appropriate non-specific CPT or HCPCS code.*

Only use a non-specific CPT or HCPCS code when there is no code available with a narrative that accurately describes the drug being administered or the drug's route of administration. **Drugs billed with a non-specific code are manually priced, and therefore must be submitted on a paper claim or submitted using the 837P/electronic claim submission and followed with a paper attachment.** When drugs and biologicals are billed using National Drug Codes (NDCs), they must be submitted on a pharmacy claim form and sent to ACS for processing. More information about the 837P/electronic claim submission is available in IHCP provider bulletin *BT200364*. Non-specific codes are reimbursed based on the AWP for the National Drug Code (NDC) indicated, multiplied by the number of units administered. All medical claims billed with a non-specific code must have an attachment indicating the appropriate NDC and dose administered, or the NDC and the dose administered can be written on the claim itself. Claims submitted without this information are denied.

> *Note: As published in IHCP provider bulletin BT200210, Synagis must be prior authorized for the RSV season. The approval period will be October 15 through April 30 of the next year, for maximum of six doses.*

Immunizations and Screenings

The procedure codes listed in Table 3.5 are the codes routinely used to bill for HealthWatch/EPSDT immunizations and screening tests.

Table 3.5 – Procedure Codes for Immunizations and Screens

Code	Code Definition
81000	Urinalysis
80100	HIV/AIDS
86550	Sickle Cell test
86580	TB Mantoux
90645	Hemophilus influenza b, HbOC conjugate
90647	Hemophilus influenza b, PRP-OMP conjugate
90648	Hemophilus influenza b, PRP-T conjugate
90669	Pneumoccocal conjugate, polyvalent
90700	DTaP
90701	DTP
90702	Tetanus-Diphtheria

(Continued)

Table 3.5 – Procedure Codes for Immunizations and Screens

Code	Code Definition
90707	MMR
90713	Polio-IPV
90716	Varicella (chicken pox)
90718	Tetanus-Diphtheria (adults)
90720	DTP-HIB
90721	DTaP – HIB
90742	HBIG
90744	Hepatitis B, newborn to 11 years
90745	Hepatitis B, 11 to 19 years
90746	Hepatitis B, 20 years and older
90747	Hepatitis B, dialysis or immunosuppressed patient, any age
92551	Audiometry testing
99173	Screening test of visual acuity

Diagnosis Codes

To receive appropriate reimbursement, all procedure codes must be accompanied by a diagnosis code. For a HealthWatch/EPSDT visit, screen, or immunization, diagnosis code V20.2, Routine infant or child health check, **must be used as the primary diagnosis code**. These codes are not subject to TPL edits when submitted in conjunction with the primary diagnosis code V20.2.

Please include all applicable diagnosis codes (up to four) and procedure codes on all claims for HealthWatch/EPSDT visits.

Required EPSDT Referrals

HealthWatch providers are responsible for making the following required referrals at indicated ages or when screening results indicate a problem:

- Dental, vision, and hearing
- Lead screening

Dental and Vision

Refer children for dental services beginning at 24 months old or as early as 12 months old if indicated. Vision referrals must be made when objective screen methods indicate a referral is warranted.

Hearing

Refer any newborns identified under the universal newborn hearing-screening program (UNHS) to First Steps. Refer older children for additional testing and treatment when screening results identify a possible hearing deficit.

Lead Screening

Blood lead screening must be performed at the nine-month or 12-month visit and again at the 24-month visit. If at high risk, blood lead screening should be initiated at the six-month visit. Subsequent screenings are required for at-risk patients. **When a blood lead screening is performed, use the exposure diagnosis code (V15.86) in addition to the primary diagnosis code of V20.2.**

> *Note: The lead toxicity code should only be used when children are diagnosed as lead exposed.*

The OMPP recommends that blood samples drawn for lead screening be sent to labs participating in the Indiana Childhood Lead Poisoning Prevention Program (ICLPPP) to ensure that test results are recorded in the ICLPPP database. The ICLPPP provides medical supplies, mailing containers, and postage for providers registered in its program and tracks blood lead screening results by geographic area to identify areas at risk. There are three ICLPPP laboratories:

- Vanderburgh County Department of Health
- Marion County Department of Health
- Indiana State Department of Health, located in Marion County

To find out where to send blood samples and how to become a provider in the ICLPPP network, contact a local health department, or the Indiana Family Helpline at 1-800-433-0746, or the ICLPPP at (317) 233-1250.

Providers that use the ICLPPPs postage-paid kit cannot bill IHCP a conveyance fee for conveying samples to the lab. However, providers that send blood samples to ISDH/ICLPPP laboratories for testing can use code *36415*, Venipuncture/finger stick, to indicate that blood draws were made. The distinction should be made by diagnosis to differentiate between individuals being tested to rule out lead screening and those that have been diagnosed or are being treated for lead poisoning.

When forwarding blood samples to ISDH/ICLPPP, please include the PMP provider number and authorization code for members of the Prime*Step* PCCM delivery system on the paperwork accompanying the sample. If the member is enrolled in an MCO in the RBMC delivery system, please include the MCO PMP authorization and referral information.

Providers that send blood samples to private labs for testing should use the codes in Table 3.6, when appropriate.

Table 3.6– Blood Samples at Private Labs

Code	Code Definition
36415	Venipuncture/finger stick
99000	Conveyance fee for sending blood samples from provider's office*
99001	Conveyance fee for sending samples other than from provider's office*

> ** Can only be submitted if the provider incurs an expense associated with the conveyance.*

Billing for EPSDT Visits and Office Visits at the Same Time

If a patient is evaluated and treated for a problem during the same visit as an EPSDT annual exam or well child service, the problem-oriented exam can be billed separately accompanied by the *-25* modifier (separate significantly identifiable E/M service). The problem must require additional moderate level evaluation to qualify as a separate service on the same date. The IHCP does not currently require that the charge be reduced, as is required by Medicare. The provider can bill usual and customary charges. IHCP reimbursement is allowed at the lesser of the submitted charge or the maximum fee for each code. However, the total billed charge must not be more than the provider charges for similar services provided to private-pay patients.

Missed Appointment Procedures

Members who miss HealthWatch appointments or follow-up appointments must be identified and their names must be forwarded to the member's MCO, the Hoosier Healthwise Helpline, or the Hoosier Healthwise benefit advocate (BA). Refer to *Section 2: Contact Information* for the telephone numbers. Member services from each of these entities follow up with the members.

Through December 31, 2003, providers that choose to submit a claim for a missed appointment should use HCPCS procedure code *X3067, Missed Appointment*, along with diagnosis code V20.2 to designate a HealthWatch exam. As of December 31, 2003, the IHCP no longer uses local codes. Providers should refer all Hoosier Healthwise members who miss appointments to the member services for the appropriate MCO and the Hoosier Healthwise Helpline at 1-800-889-9949 if the member is enrolled in the PCCM delivery system. Providers should refer all members in the *Medicaid Select* Program who miss appointments to the *Medicaid Select* Helpline at 1-877-633-7353.

Claim submission for missed appointments is not required. These claims are used for data gathering only; no reimbursement is made for missed appointments.

Federally Qualified Health Centers and Rural Health Clinics

Effective April 1, 2003, the IHCP made significant changes to the method of filing claims and the reimbursement methodology for Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) based on information from *Section 702 of the Medicare, Medicaid, and State Children's Health Insurance Program (SCHIP) Benefits Improvement and Protection Act of 2000 (BIPA)* that was printed in IHCP provider bulletin *BT200152*. The new billing procedures were implemented April 1, 2003. IHCP provider bulletin *BT200318* provides complete information about the new billing methodology.

Services provided to a Hoosier Healthwise or Medicaid Select PCCM member, such as immunizations, at a location other than the PMP's office require the Memorandum of Collaboration as well as authorization information. If the visit does not satisfy the criteria for an encounter, the T1015 should not be used and the services should be reflected in the facility's cost report. Allowable EPSDT and pregnancy services provided during the encounter visit that are appropriately billed will continue to bypass TPL.

Claims for members in an RBMC plan should continue to be billed in the current manner to the applicable MCO. The T1015 encounter code should not be included on these claims. Myers and Stauffer LC will reconcile all MCO claims to the provider specific PPS rate quarterly and settlements will be made at that time.

The new billing methodology is the same for all FQHCs and RHCs. Providers should bill for the CPTs for all EPSDT services provided on each date of service along with the T1015 when there is a valid encounter. Providers are still required to maintain appropriate documentation of the screening services.

Dental claims for RHCs and FQHCs should be billed on an ADA Dental claim form using current dental terminology (CDT) codes. The T1015 encounter code should not be included on the dental claim form. Myers and Stauffer, LC, reconciles dental claims to the provider-specific prospective payment system (PPS) rate quarterly and makes settlements at that time. This reconciliation will continue until a national dental code is established to act as an all-inclusive code on the dental claim form.

For Dates of Service Prior to April 1, 2003

EPSDT services provided at the FQHC for patients who are not Hoosier Healthwise or *Medicaid Select* members are billed using T1015 for dates of service January 1, 2002, and after. Prior to January 1, 2002, services should be billed using X3004. Services provided to Hoosier Healthwise or *Medicaid Select* members must be billed using the appropriate CPT codes.

Provider based rural health clinics (RHCs) must use the appropriate CPT codes for EPSDT services provided. Independent RHCs should bill using T1015 for valid EPSDT services with dates of service January 1, 2002. For dates of service prior to January 1, 2002, providers should bill using X3004.

Section 4: Recommended Screening Techniques, Referral Standards, and Anticipatory Guidance

Family and Medical History

The history of the patient is an important factor in making a proper assessment of the patient's health. The health watch/EPSDT screening physician has the responsibility of obtaining a family and medical history as part of the health watch screening examination.

The categories that should be covered during the history-taking portion of the health watch/EPSDT screen are outlined below. Modifications should be made which are appropriate for the age and gender of the child. Significant findings should be noted on the child's medical record (see the subsection *Documentation* of *Section 3: HealthWatch (EPSDT) Information* for suggested methods of simplifying EPSDT documentation).

The following is a suggested outline for the Health and Development History/Database:

- Reason for visit
- Initial observations of parent, child, and family interactions and identification of caregivers
- Perinatal history (this child)
  - *Pregnancy:* Prenatal care including trimester when initiated; habits, including use of drugs, alcohol, tobacco; illnesses; accidents; hospitalizations; planned or unplanned
  - *Birth:* Description of labor and delivery; anesthesia; complications; location of birth; full term or premature (gestational age of child)
  - *Neonatal:* Condition at birth; measurements; nursery course; length of stay; complications or problems; treatment; breast or bottle fed
- Nutritional status
  - Questions related to feeding or food habits to elicit nutritional risk
  - Review the following: height for age and weight for height, laboratory tests, and findings on health history and physical examination
- Developmental history
- Medical history
- Body systems review
- Family health history

Note the presence of diseases such as the following in maternal and paternal families: hypertension, heart disease, stroke, obesity, cystic fibrosis, allergy, asthma, emphysema, tuberculosis, diabetes mellitus, kidney disease, arthritis, cancer, anemia, hemoglobin disorder, mental retardation, seizures, mental illness, migraine, congenital anomalies, hereditary or familial conditions, sexually transmitted disease, and substance use or abuse.

- Psychosocial and lifestyle history
- Child's mental and emotional health
- Family household and environment

Assessment of Physical and Mental Health Development

Physical Examination

A complete and unclothed physical exam must be given each time a HealthWatch screen is performed. All areas of a routine general physical exam are included in the HealthWatch screen. Because federal and state Medicaid requirements emphasize certain areas of the examination, an *Indiana HealthWatch Program Periodicity and Screening Schedule* (*Appendix A*) has been developed outlining these areas and showing what age of the certain procedures must be completed. The information contained in this section suggests various screening techniques and standards for referral if further evaluation or treatment is needed as a result of the HealthWatch screen.

The following protocol is suggested when performing a HealthWatch exam:

- Measurements
- Height
- Weight
- Weight for height
- Head circumference (birth through two years)
- Blood pressure (from three years)
- General physical examination and review of the following systems:
  - Parent, child, and physician interaction
  - General appearance and behavior
  - Nutrition and growth
  - Skin and hair
  - Head
  - Face
  - Eyes
  - Ears
  - Nose, mouth, and throat
  - Teeth and gums
  - Musculoskeletal system
  - Neck
  - Lymph nodes
  - Cardiovascular system
  - Respiratory system
  - Gastrointestinal system
  - Urogenital system
  - Endocrine system
  - Nervous system
  - Other

Suspect or positive findings should be summarized and discussed with the parent and child and a plan of care developed.

Height, Weight, Head Circumference

Guidelines for obtaining measurements:

- *Weight is required at each visit for all ages.* Infants and small children should be weighed on a table model beam scale. Older children who can stand without support can be weighed on a floor model beam scale. Scales should be balanced prior to weighing and should be checked and adjusted for accuracy according to the manufacturer's specifications.

- *Height is required at each visit for all ages.* Infants and children as old as two years old and children with low birth weight, failure to thrive, or certain developmental disorders, or who cannot stand, should be measured supine on a firm surface using a fixed headboard and footboard when possible. For older children who are able to stand without support use a nonstretchable measuring tape fixed to a true vertical surface.
- *Head circumference* must be measured at every visit for infants and children through two years old.
  - Measure the head with a cloth, steel, or disposable paper tape
  - Apply the tape around the head from the supraorbital ridges anteriorly to the posterior point (usually the external occipital protuberance) giving the maximum circumference
- *Standards for further evaluation or referral:* Refer to the National Center for Health Statistics' percentile standards in current age and gender-specific physical growth charts by Ross Laboratories, Columbus, OH, 43216. Any significant deviation is a basis for further evaluation and, if necessary, a referral.

Blood Pressure

Blood pressure must be checked at every screening visit for all children three years of age and older. However, blood pressure can be taken on younger children if a provider decides it is appropriate.

- Take the blood pressure with the appropriate sized pediatric or adult cuff
- Record the reading in the patient chart

Standards for Further Evaluation or Referral: Refer to current percentile charts published by the AAP for the normal blood pressure for various ages. Any significant deviation is a basis for further evaluation and, if necessary, referral.

Dental Observation And Screening

An oral screening should be included as part of each HealthWatch physical exam. This includes an assessment of the following:

- Palate, cheeks, tongue, and floor of mouth
- Dental ridges (including erupting teeth)
- Gums for evidence of infection, bleeding, and inflammation
- Malformation or decay of erupting teeth
- Need for daily fluoride intake
- Need for dental referral regardless of age for a complete examination of all hard and soft tissues within the oral cavity

Early tooth loss, pain, and infection caused by dental decay can result in failure to thrive, impaired speech development, school absences, inability to concentrate, and reduced self-esteem. According to a survey by the National Center for Health Statistics, children from families with lower incomes missed significantly more school because of dental problems than did children from families with higher incomes. Poor oral health has been related to decreased school performance, poor social relationships, and less success later in life.

Required Dental Referral

In addition to the oral examination, a referral to a dentist must be a part of every screen beginning at 24 months of age and continuing through 20 years old. Dental referrals can be made as early as 12 months old, if indicated. Children should visit the dentist every six months to receive preventive dental care. The first examination by a dentist can reveal decay, unerupted or missing teeth, and the need for prophylaxis or treatment.

Dental Anticipatory Guidance for Parents of Infants

Parents should be counseled on the importance of taking care of their baby's teeth. Teeth are susceptible to decay as soon as they appear in the mouth. After each feeding, the child's teeth and gums should be wiped with a damp cloth. Brushing the teeth can be done as soon as they appear.

Preventing Baby Bottle Tooth Decay

Following is information taken from a flyer printed by the ISDH about baby bottle tooth decay. Copies of this flyer and more information can be obtained at the following location:

Indiana State Department of Health
Oral Health Services
2 North Meridian St.
Indianapolis, IN 46204
Or call the Family Helpline at 1-800-433-0746

Inappropriate use of bottle-feeding or breast-feeding could result in a destructive decay process affecting the child's front teeth. If decay is extensive there is usually a great deal of infection. The infection could cause developmental defects in permanent teeth. Early loss of primary teeth can cause crowding of permanent teeth.

Systemic Fluoride Recommendations

A child who has access to the appropriate concentration of systemic fluorides from birth through 14 years old will be likely to experience significantly less tooth decay over a lifetime. The amount of fluoride supplementation necessary for a given child depends upon the existing concentration of fluoride in the child's drinking water and the age of the child.

The information below was taken from a flyer distributed by the Indiana State Department of Health titled, *Prescription Fluoride Supplements - A Reminder*, by Mark E. Mallatt, D.D.S.

In Indiana almost 97 percent of the population served by communal water supplies receive optimally fluoridated water (0.7-1.2 ppm). This level has a profound effect in reducing dental carries. Also, the ground water in many areas of rural Indiana contains optimal levels of fluoride. Prescribing fluoride supplements to individuals already receiving optimally fluoridated water is not necessary and could result in mild dental fluorosis. Therefore, it is imperative to have the water tested for fluoride content by the ISDH or the IU Department of Dentistry before prescribing such supplements. Health professionals should not assume that patients who receive water from wells receive fluoride deficient water. Commercially available bottled spring water will also contain varying amounts of fluoride depending on its source (distilled and deionized water, however, is virtually fluoride free). With so many fluoride preparations such as toothpaste, rinses, vitamins, and so forth, currently available, it is essential to prescribe the correct amount of fluoride to prevent tooth decay and, at the same time, prevent dental fluorosis. Table 4.1 shows the recommended supplemental fluoride dosage schedule.

Table 4.1 – Supplemental Fluoride Dosage Schedule
(In mg. of fluoride per day)

Age of Child	Less than 0.3	0.3 to 0.6	Greater than 0.6
6 mos. to 3 yr.	0.25	0	0
3 to 6 years	0.50	0.25	0
6 to 16 years	I.00	0.50	0

Recommended by the Council on Dental Therapeutics of the American Dental Association and the Committee on Nutrition of the American Academy of Pediatrics.

Water analysis for fluoride content can be completed by the ISDH or the IU School of Dentistry at the following address:

Oral Health Institute
415 Lansing St.
Indianapolis, IN 46202
Telephone (317) 274-8822

The $8 charge is not covered by the IHCP. For more information call Oral Health Services, ISDH, at (317) 233-7417.

Table 4.2 - Periodicity Schedule for HealthWatch/EPSDT Dental Observation and Screening

Age of Child	Recommended (S) or Required (R)	Services
Younger than 12 months	S	Direct referral to a dentist for medically appropriate services, if warranted by injury, disease, congenital abnormality, or other cause.
12 to 24 months	S	Direct referral to a dentist, if medically appropriate.
24 months	R	Direct referral to a dentist for examination, preventive dental care, and anticipatory guidance.
24 months through 20 years	R	Regular dental assessments at intervals defined by the dentist (approximately every six months) for the individual patient. Assessment should include examination, preventive dental care, and anticipatory guidance.

Please refer to the Fluoride Dosage Schedule in Table 4.1 for age-appropriate supplemental fluoride dosage recommendations from the ADA and the AAP.

For information about the prevention of baby bottle tooth decay, please contact ISDH at the following address:

Oral Health Services
2 North Meridian
Indianapolis, IN 46204

Vision Observation And Screening

Each HealthWatch screen must include a visual observation with an external eye examination and routine testing for visual acuity.

Undetected vision problems occur in five to 10 percent of preschool children. The most serious of these problems is amblyopia, a loss of visual acuity and binocular vision that becomes irreversible after five years old.

Required Vision Referral

Vision referrals must be made when objective screen methods indicate a referral is warranted.

External Examination

External examination should include general inspection of the lids and eyeballs, noting prominence, size, and position, as well as growths, inflammations, discharge, or vascular injection. Forward protrusion (exophthalmos) or retraction (enophthalmos) of the globe should also be noted.

Visual Acuity - Infants

Visual acuity is difficult to evaluate in infants. Providers should observe whether an infant will follow a light or a bright attractive toy in different directions of gaze. Each eye should be tested separately. If the infant fails to respond to such testing, the provider should observe the pupillary responses for reaction to direct light stimulus.

Infants can be tested also by alternately covering each eye. If visual acuity is poor in one eye, the infant will resist actively when the good eye is covered and vision is disturbed, but will be much less affected when the eye with decreased vision is covered.

Visual Acuity – Children 36-59 Months

The summary of a task force report on preschool vision screening published in *Pediatrics, Vol. 106, No. 5, November 2000*, indicated a lack of consistency in preschool vision screening recommendations among programs in the United States, the lack of data, and effectiveness of current screening methodologies. Responding to the need for useful screens to detect amblyopia risk factors and other significant problems, an expert panel convened. The panel concluded that the most direct way to detect amblyopia (monocular decreased vision) in three and four year old children is to assess monocular visual acuity. Recommended tests include HOTV, Lea symbols, or tumbling E charts, because they allow screening of younger children. Isolated optotypes with surround bars are also acceptable. Stereopsis testing is recommended to detect strabismus as an amblyopiogenic factor. Table 4.3 provides testing procedures and passing criteria for these commercially available tests.

Table 4.3 – Testing Procedures

Function to be Evaluated	Type of Test	Specific Test	Recommended Testing Procedures	Passing Criteria
Monocular distance acuity	1. Linear acuity 2. Isolated optotypes with surround bars*	1. HOTV, Lea symbols, tumbling 2. HOTV cards with surround bars	Test distance = 10 ft (3m) Pretest (performed binocularly) Test child's ability to perform test by having child identify or match each of the four optotypes on a line that is expected to be suprathreshold (20/100 or greater). Child must successfully identify each of the four optotypes. Test procedure (performed monocularly) Test child's ability to identify or match optotypes on the line used in the pretest. To proceed, the child must identify or match four or five optotypes on the pretest line. The test child's ability to identify or match optotypes on the critical line. Repeat test procedure with other eye.	Child must identify or match four of five optotypes on the critical line with each eye tested monocularly. Critical lines 20/40 at 36 -<48 months and 20/30 at 48-59 months.

(Continued)

Table 4.3 – Testing Procedures

Function to be Evaluated	Type of Test	Specific Test	Recommended Testing Procedures	Passing Criteria
Stereopsis	Random dot stereogram	Random Dot E	Test distance = 40 cm (630 arcsec) All testing, including pretesting, should be performed binocularly with the polarized glasses on. Pretest – Test child's ability to perform test by having child identify the location of the three-dimensional E on four of five trials (E on left or right; above or below). Test procedure – Test child's ability to identify the location for the stereo E. Tester should use five presentations, varying location in a nonsystematic manner.	Child must locate stereo E on four of five presentations. **

**Isolated optotypes without surround bars should not be used because they overestimate acuity with amblyopia.*

***From a statistical perspective, it would be ideal to require a child pass five of five trials because the probability of achieving this criterion by simply guessing is less than five percent. In reality, many children will have difficulty attending consistency for five trials. Therefore, four of five correct passing criterions are considered acceptable, even though the probability of passing by chance is 16.5 percent.*

Referral Standards

External Area: Abnormalities that cannot be adequately evaluated and treated by the screening physician should be referred to a specialist for further evaluation.

Acuity: Refer to the following Chronology of Visual Development in Table 4.4. Any marked deviation from these guidelines is a basis for referral to a specialist for further evaluation.

Children already wearing glasses should be tested with their glasses. If they pass, record measurement and nothing further needs be done. If they fail, refer for re-evaluation to the eye practitioner who prescribed the lenses.

A child may be referred if parental complaints warrant a referral. (Generally, sitting close to the television, without other complaints and with normal acuity, is **not** a reason for referral). Children failing a test for hyperopia can be referred for additional diagnosis and treatment.

Table 4.4 – Chronology Of Visual Development

Age	Level of Development
Birth	Awareness of light and dark and closes eyelids in bright light.
Neonatal	Rudimentary fixation on near object (three to 30 inches).
Two weeks	Transition fixation, usually monocular, at a distance of roughly three feet.
Four weeks	Follows large, conspicuously moving objects.
Six weeks	Moving objects evoke binocular fixation briefly.

(Continued)

Table 4.4 – Chronology Of Visual Development

Age	Level of Development
Eight weeks	Follows moving objects with jerky eye movements. Convergence beginning to appear.
12 weeks	Visual following now a combination of head and eye movements and convergence improving. Enjoys light objects and bright colors.
16 weeks	Inspects own hands. Fixates immediately on a one-inch cube brought within one to two feet of eye. Vision 20/300 to 20/200 (6/100 to 6/70)
20 weeks	Accommodative convergence reflexes all organizing. Visually peruse lost rattle. Shows interest in stimuli more than three feet away.
24 weeks	Retrieves a dropped one-inch cube, can maintain voluntary fixation of stationary object even in the presence of competing moving stimulus, and hand-eye coordination appearing.
26 weeks	Will fixate on a string.
28 weeks	Binocular fixation clearly established.
36 weeks	Beginning of depth perception.
40 weeks	Marked interest in tiny objects and tilts head backward to gaze up. Vision 20/200 (6/70)
52 weeks	Fusion beginning to appear. Discriminate simple geometric forms (squares and circles). Vision 20/180 (6/60)
12 – 18 months	Looks at pictures with interest.
18 months	Convergence well established and localization of distance is crude - runs into large objects.
Two years	Accommodation well developed. Vision 20/40 (6/12)
Three years	Convergence smooth and fusion improving. Vision 20/30 (6/9)
Four years	Vision 20/20 (6/6)

Table 4.5 – Periodicity Schedule for HealthWatch/EPSDT Vision Observation and Screening

Age of Child	Recommended (S) or Required (R)	Services
Up to three years	S	Visual observation with an external eye examination; subjective screening by history. Refer child to an appropriate specialist if abnormality suspected.
Three to five years	R	Annual objective screening test by a standard testing method. If warranted, refer child to an appropriate specialist.
Six, eight, 14, 16, and 18 years	S	Visual observation with an external eye examination; subjective screening by history. Refer child to an appropriate specialist if abnormality suspected.
10, 12, and 18 years	R	Objective screening test by a standard testing method. If warranted, refer child to an appropriate specialist.

Refer to an appropriate vision or eye specialist any patient exhibiting a marked deviation from the chronology of visual development in Table 4.4.

Hearing Observation And Screening

The most critical period for learning language is the first two years of life. If hearing problems are not detected until after this time, lost ground in language development may never fully be regained. Screening tests that vary according to age must be part of the HealthWatch/EPSDT screen. The early detection of hearing loss is an urgent duty of any physician caring for young children.

Newborn Hearing Screening

Universal newborn hearing screening (UNHS) is designed to identify infants, to assure appropriate follow-up intervention, and to collect information on the evidence of hearing loss using the initial guidance package was published by ISDH, and since July 1, 2000, all hospitals in Indiana must conduct the universal newborn hearing screening.

Currently there are two methods available to conduct newborn hearing screening that possesses a high degree of sensitivity and specificity. These are the auditory brainstem response (ABR) and Evoked Otoacoustic Emissions (OAE).

The hospital is required to complete a second screening test if newborn fails the first screening. All cases requiring follow-up are to be referred by the hospital to the local First Steps' system point of entry (SPOE). These referrals may need to have linkage coordinated by First Steps to service providers, or may only require that First Steps monitor the follow-up services coordinated by the hospital. Diagnostic testing is to be conducted only after failure to pass two screening tests. For further information, contact the ISDH at (317) 233-1231.

Infant Hearing Screening

Noisemakers can be used to screen infant's hearing. High frequencies can be tested with a squeaky toy or small bell, and middle frequencies with a rattle or piece of tissue paper. While the infant is distracted with a visual stimulus such as a toy or brightly colored object, the noisemaker is sounded outside of the field of vision. Normal responses are as follows:

- At four months, there is a widening of the eyes, a cessation of previous activity, and possibly a slight turning of the head in the direction of the sound.
- At nine months or older, the child should usually be able to locate sound, whether it comes from above or below.

Many hearing tests can give **falsely normal results**, such as banging pots together or hearing a low flying airplane. Most children with significant hearing deficits have residual hearing and will respond to very loud noises. However, they are educationally and socially deaf if they cannot hear normal speech sounds.

Hearing Screening of Older Children

At age three, a child can begin to be tested with a pure tone audiometer. However, the HealthWatch/EPSDT Program does not require an audiometric screening until the child reaches four years old. If the child is unable to cooperate, the test can be deferred until the next exam. Document deferral due to inability to cooperate in the patient record.

Hearing screening must be done with an audiometer or audioscope. The audiometer and audioscope must be recalibrated annually. Providers that do not wish to perform the objective hearing screen can refer the child to an audiologist for screening.

Hearing tests are given by the Department of Education in grades one, four, seven, and 10. Several schools also test kindergarten children. These screening efforts should not be duplicated unless the child is at risk and the situation warrants rescreening. Screening results from the school, or verbal confirmation by the parent, should be documented in the patient's medical records. Using an audiometer for testing children younger than four years old is left to the individual practice.

Referral Standards

When you suspect or have confirmed a chronic hearing deficit, an appropriate referral should be arranged to do precise testing. If the hearing deficit is confirmed, the patient should be referred to an otolaryngologist for examination in an attempt to determine the cause of the hearing loss. The following categories of patients are often associated with unsuspected hearing loss and should be carefully assessed and referred, if necessary.

High Risk Register

- Neonates (birth to 28 days) who fall into one or more of the 10 risk criteria identified by the Joint Committee on Infant Hearing (1990) are considered at risk for hearing impairment and should receive audiologic screening. The factors frequently referred to as the high risk register (HRR) are:
  - Family history of congenital or delayed onset childhood sensorineural impairment
  - Congenital infection known or suspected to be associated with sensorineural hearing impairment such as toxoplasmosis, syphilis, rubella, cytomegalovirus, and herpes
  - Craniofacial anomalies, including morphologic abnormalities of the pinna and ear canal, absent philtrum, low hairline, and so forth
  - Birth weight less than 1500 grams (<3.3 lbs)
  - Hyperbilirubinemia at a level exceeding indication for exchange transfusion
  - Ototoxic medications, including, but not limited to, the aminoglycosides, used for more than five days (such as, gentamicin, tobramycin, kanamycin, streptomycin) and loop diuretics used in combination with aminoglycosides
  - Bacterial meningitis
  - Severe depression at birth which may include infants with APGAR scores of 0-3 by five minutes or those who fail to initiate spontaneous respiration by 10 minutes or those with hypotonia persisting to two hours of age
  - Prolonged mechanical ventilation for a duration equal to or greater than 10 days (such as, persistent pulmonary hypertension)
  - Stigmata or other findings associated with a syndrome to include sensorineural hearing loss (such as Wardenburg or Usher's Syndrome)
- Infants (29 days to two years)
  - Parent or caregiver concerns about hearing, speech, or developmental delay
  - Bacterial meningitis
  - Neonatal risk factors that may be associated with progressive sensorineural hearing loss (such as, cytomegalovirus, prolonged mechanical ventilation, and inherited disorders)
  - Head trauma, especially with either longitudinal or transverse fracture of the temporal bone
  - Stigmata or other findings associated with syndromes known to include sensorineural hearing loss (such as, Wardenburg or Usher's Syndrome)
  - Ototoxic medications including, but not limited to, the aminoglycosides used for more than five days (such as, gentamicin, tobramycin, kanamycin, streptomycin and loop diuretics used in combination with aminoglycosides)
  - Children with neurodegenerative disorders such as neurofibromatosis, myoclonic epilepsy, Freldrich's Ataxia, Huntington's Chorea, Werdnig-Hoffman Disease, Tay-Sach's Disease, Charcot-Marie Tooth Disease, any metachromatic leukodystrophy, or any infantile demyelinating neuropathy
- Screening test failures
  - Infants who fail any of the office screening tests described above should be given more sensitive tests to clarify hearing status.
- Suggestive symptoms in infants

  - Parents are concerned. Most mothers of deaf children have some suspicion of the problem by the time the child is six months old and sometimes earlier. When the parent suspects hearing impairment, a reliable hearing test should be given.
  - Not awakening to sound. A normal sleeping infant sometimes awakens to sounds in other parts of the house. If this has not happened, the mother should be asked to be alert for it and report it at the next HealthWatch visit. If it does not occur, the child requires referral.

- Speech delays
  - Before any child is labeled as having mental retardation, autism, auditory agnosia, or a developmental speech delay, a valid hearing test is required. Verbal communication depends on hearing. If the patient is old enough to cooperate with pure tone audiometry and the results are normal, referral to an audiologist is not needed. Referral to an audiologist should be preceded by otoscopic examination.

Table 4.6 – Periodicity Schedule for HealthWatch/EPSDT Hearing Observation and Screening

Age of Child	Recommended (S) or Required (R)	Services
Newborn	S	Newborn hearing screening via fully automated auditory brain stem response, if available.
Newborn	R	All patients considered to be at risk for hearing deficit are to be screened at this time.
Under 12 months	S	Subjective screening, by history and/or other infant screening techniques; refer child to an appropriate hearing specialist, if warranted.
12 months through three years	S	As early as possible, perform an objective screening using a standard testing method. Refer those at risk or suspected of hearing deficit to a specialist.
Four to five years	R	Audiometric screening with an audiometer or audioscope (child may be referred to an audiologist for screening); refer child at risk or suspected of hearing deficit to an appropriate specialist.
Four, eight, 14, 16, and 20 years	S	Subjective screening, by history and/or other method; refer child with suspected hearing deficit to an appropriate specialist.
10, 12, and 18 years	R	Objective hearing screening by a standard testing method; (hearing tests are given by the Indiana Dept. of Education in grades 1, 4, 7, and 10 - several schools also test kindergarten students). Do not duplicate school screenings unless the child is considered at risk and rescreening is warranted.

Refer to the high-risk register for categories of patients often associated with unsuspected hearing loss.

Developmental and Behavioral Assessment

Assessing Development

Developmental assessment is an ongoing process and, therefore, is to be completed as part of each HealthWatch/EPSDT screen. It consists of a range of activities to determine whether the child's development progress is within a normal range of achievement according to age and cultural background. A developmental history is important. Parents usually are able to give an accurate history of the child's development. In addition to history and observation, a developmental assessment

must be done. For regular patients, an ongoing recording in the child's chart of developmental milestones may be sufficient to make a judgment about developmental progress.

Children Younger Than Five Years Old

For children younger than five years old, the chart included in this section depicting milestones for motor language and social development, may be used in the assessment process.

- *Motor skills:* Although practice of motor movements has a slight influence on the rate of development, maturation usually plays a much greater role. The newborn infant can perform a number of motor movements mainly of a reflex type.

  Motor development involving the hands tends to proceed along a definite sequential course. The child first looks from the hand to the object and then attempts to grasp objects with two hands. Grasping with the palm of the hand is learned first, using the ulnar side of the hand initially and later the radial side. Eventually, grasping with the thumb and index finger is mastered.

- *Social activity and behavior:* Questions should be asked to determine how the child relates to family and peers and whether there is any noticeable deviation in any behavior. Observe for similar behavior in the office.

- *Speech development:* Attention should be paid to the child's speech pattern to see whether it is appropriate for the child's age. Language remains the best predictor of future intellectual endowment and should serve as the common denominator comparing its rate of development with other areas including gross motor, problem solving, adaptive, and social skills. If a provider decides during the screening process that further evaluation is needed, then one of the standard speech and language tests may be given.

- *Developmental tests:* After observing the child in the various areas of development, the provider may decide that a more in-depth evaluation is needed. The provider can elect to use an objective developmental screening test and receive additional reimbursement. Developmental testing is recommended from six months through four years old.

  Suggested examples of tests that are reliable, valid, and culturally sensitive for this age group include, but are not limited to, the following:
  - Denver Developmental Screening Test II
  - Denver Prescreening Developmental Questionnaire (PDQ)
  - Denver Developmental Screening Test (DDST)

The Denver II is a revised and restandardized test developed from the original Denver Developmental Screening Test (DDST), The Denver II has added 22 language items and modified many of the existing DDST items. **Training sessions on the administration of the Denver II are offered through the United Training System as part of Indiana's First Steps Program. Persons interested in receiving this training should call the First Steps Program at 1-800-887-1467.**

Additional information concerning the First Steps program is located in *Indiana's First Steps Program* in this section.

Table 4.7 – Developmental Milestones/Language Skills

Age	Gross Motor	Visual Motor	Language	Social
One month	Raises head slightly from prone, makes crawling movements, lifts chin up	Has tight grasp, follows to midline	Alerts to sound (for example, by blinking, moving, startling)	Regards face
Two months	Holds head in midline, lifts chest off table	No longer clenches fists tightly, follows objects past midline	Smiles after being stroked or talked to	Recognizes parent
Three months	Supports on forearms in prone, holds head up steadily	Holds hands open at rest, follows in a circular fashion	Coos (produces long vowel sounds in musical fashion)	Reaches for familiar people or objects, anticipates feeding
Four to five months	Rolls front to back, back to front, sits well when propped, supports on wrists and shifts weight	Moves arms in unison to grasp, touches cube placed on table	Orients to voice, five months –turns head towards bell, says “ah goo,” razzing	Enjoys looking around environment
Six months	Sits well supported, puts feet in mouth in supine position	Reaches with either hand, transfers, uses raking grasp	Babbles, eight months -- “dada/mama” indiscriminately	Recognizes strangers
Nine months	Creeps, crawls, cruises, pulls to stand, pivots when sitting	Uses pincer grasp, probes with forefinger, holds bottle, finger feeds	Imitates sounds, waves bye-bye. 10 months “dada/mama” discriminatory. 11 months – uses one word	Starts to explore environment, plays pat-a-cake
12 months	Walks alone	Throws objects, lets go of toys, hand release, uses mature pincer grasp	Follows one-step command with gesture, uses two words, 14 months – uses three words	Imitates actions, comes when called, cooperates with dressing
15 months	Creeps upstairs, walks backwards	Builds tower of two blocks in imitation of examiner, scribbles in imitation	Follows one-step command without gesture, uses four to six words and immature jargoning (runs several unintelligible words together)	
18 months	Runs, throws toy from standing without falling	Turns two to three pages at a time, fills spoon and feeds himself	Know seven to 20 words, points to one body part when named, uses mature jargoning (includes intelligible words in jargoning)	Copies parent in tasks (such as, sweeping, dusting) and plays in company of other children

(Continued)

Table 4.7 – Developmental Milestones/Language Skills

Age	Gross Motor	Visual Motor	Language	Social
21 months	Squats in play, goes up steps	Builds tower of five blocks, drinks well from cup	Points to three body parts, uses two-word combinations. Points to five body parts	Asks to have food and to go to the toilet
24 months	Walks up and down steps without help	Turns pages one at a time, removes shoes, pants, and so forth, imitates stroke	Uses 50 words, two-word sentences, and three pronouns, names objects in pictures	Parallel play
30 months	Jumps with both feet off floor, throws ball overhand	Unbuttons, holds pencil in adult fashion, differentiates, horizontal and vertical line	Uses pronouns "I, you, me" discriminately	Tells first and last names when asked, gets himself drink without help
3 years	Pedals tricycle, can alternate feet when going up stairs	Dresses and undresses partially, dries hands if reminded, draws a circle	Uses three word sentences, uses plurals, past tense, knows all pronouns, minimum 250 words	Group play, shares toys, takes turns, plays well with others, knows full name, age, sex
4 years	Hops, skips, alternates feet going downstairs	Buttons clothing fully, catches ball	Knows colors, says song or poem from memory, asks questions	Tells tall tales, plays cooperatively with a group of children
5 years	Skips, alternating feet jumps over low obstacles	Ties shoes, spreads with knife	Prints first name, asks what a word means	Plays competitive games, abides by rules, likes to help in household tasks

Note: This information comes from: Capute, AJ and Blehl, RF: Pediatr. Clin. North Am 20:3-25, 1973; Capute, AJ, et al.: Dev Med Chilkd Neurol. In Press. 194: Capute. AJ and Accarco, PJ: Clin Pediatr 17: 847-853f, 1978.

Children from birth to three years old with suspected developmental delays may be referred to the First Steps program. Providers can call the First Steps Program at 1-800-441-STEP to obtain the name and phone number of the First Steps local council serving families in the county where the child resides. For more information on the First Steps program see the information in the following section.

Indiana's First Steps Program

Indiana's First Steps early intervention system is a comprehensive, family-centered, community-based program that provides early intervention services to infants and young children with disabilities and infants and young children who are at risk for developmental delays. The First Steps Program is not income-based.

Families who are eligible to participate in the Indiana First Steps Program include any children, ages birth to three years old who:

- Are experiencing developmental delays
- Have a diagnosed condition that has a high probability of resulting in a developmental delay
- Are at risk of having substantial developmental delay because of biological risk factors

The First Steps program can provide a multidisciplinary evaluation and assessment for referred children. An individual family service plan (IFSP) developed by parents and professionals to identify services that would achieve the best possible result for the child and the family. The IFSP then becomes the road map for the services the family and their child will receive.

All infants and toddlers are entitled to evaluation to determine eligibility, ongoing assessment, and case management. The following services are specifically listed in the regulations. If appropriate for the child and family, they must be included in the family's IFSP:

- Audiology
- Case management
- Family training, counseling, and home visits
- Health services necessary to enable the infant or toddler to benefit from the early intervention services
- Medical services only for diagnostic and evaluation purposes
- Nursing services
- Nutrition services
- Occupational therapy services
- Physical therapy
- Psychological services
- Social work services
- Special instruction
- Speech-language pathology
- Transportation (direct and related costs of travel)

Although most First Steps agencies can provide all the early intervention services needed by children with developmental delays, IHCP members have the freedom of choice of providers for IHCP-covered services. Families can choose to receive IHCP-covered services from a provider not affiliated with the First Steps Program.

In addition to the services children and their families can receive, it is important to get children with suspected or diagnosed developmental delays enrolled in the First Steps program for the following two special reasons:

- To enable eligible children and their families to receive early intervention services based on an IFSP
- To enable eligible children and their families to receive transitioning services when the child turns three years old and the Department of Education is then responsible for providing services for these children, if eligible, through an **IEP.**

Contact 1-800-441-STEP for more information about the First Steps Program.

Services authorized by First Steps for children who are not enrolled in the IHCP and some Children's Special Health Care Services (CSHCS) are billable only to First Steps. Non-First Steps services billed for IHCP member follow normal protocol for each delivery system.

Assessing Behavior and Mental Health

The federal EPSDT mandate requires regularly scheduled screens of all Medicaid-enrolled children to identify physical and mental health problems. Although the Denver II assesses a child's development in four areas, it does not adequately screen young children for emotional and behavioral problems. To make early identification of behavioral and emotional problems easier and cost-effective for busy physicians, a screening questionnaire as part of routine primary care can be used to facilitate early recognition. Many regularly used tools are available in English and Spanish. The following are examples of pediatric mental health screening tools that can be useful in performing this component of the EPSDT screen:

- Children's Depression Inventory (CDI)
- Eyberg Child Behavior Inventory
- Pediatric Symptom Checklist (PSC)

Descriptions of the screening tools are available on the Internet. The following web sites provide descriptions and additional information for each tool:

- CDI – http://ericae.net/tc3/TC019167.htm
- Eyberg Inventory – http://www.parinc.com/
- PSC – http://psc.partners.org/

Children's Special Health Care Services

CSHCS serves persons from birth to 21 years old. CSHCS provides a basic service package and a limited service package to help meet the needs of CSHCS clients. The basic service package for medically and financially eligible children includes primary care (preventive care, immunizations, and sick-child care). It also includes routine dental care and the provision of prescription medication.

Individuals can be enrolled in both IHCP and CSHCS if they qualify for both programs. The EPSDT services must first be billed to the IHCP network (fee-for-service, Prime*Step* PCCM, or RBMC) the child is assigned to before submitting the claim to CSHCS. If the child is also enrolled in First Steps and First Steps covers the service, providers should bill First Steps and First Steps coordinates billing the IHCP and CSHCS.

Sexual Maturation

Knowing the norms of sexual development and being able to describe them with some understanding is the only way of assessing the abnormal. An accurate description of the sexual maturation process aids greatly in assessing height growth patterns and prognosis, as well as future genital and reproductive development.

Secondary Sexual Characteristics

Secondary sexual characteristics are used to classify the level of sexual maturation of adolescents. The scale developed by J.M.Tanner *(Growth of Adolescent, 2nd Edition, Oxford: Blackwell Scientific Publications, 1962),* assigns sexual maturity ratings (SMR) based on pubic hair and breast development in females and pubic hair and genitalia development in males. It is important to consider both when assessing the level of maturation of adolescents. Using a standardized system is one way of clinically communicating from doctor to doctor or measuring change from time to time. The following charts list the various stages of sexual development.

Table 4.8 – Breast Development Stages

Tanner	SMR	
Stage I	B1	Preadolescent: There is elevation of the papilla only.
Stage II	B2	Breast bud stage: There is elevation of the breast and the papilla as a small mound. Areolar diameter is enlarged over Stage I.
Stage III	B3	Breast and areola are both enlarged and elevated more than in Stage II, but with no separation of their contours.
Stage IV	B4	The areola and papilla form a secondary mound projecting above the contour of the breast.
Stage V	B5	Mature stage: The papilla only projects, with the areola recessed to the general contour of the breast.

Stages IV and V are not distinct in some patients.

Table 4.9 – Standards for Genitalia Maturity Ratings for Boys

Tanner	SMR	
Stage I	G1	Preadolescent: Testes, scrotum, and penis are about same size and shape as in early childhood.
Stage II	G2	Scrotum and testes are slightly enlarged and the skin of the scrotum is reddened and changed in texture. There is little or no enlargement of the penis at this stage.
Stage III	G3	Penis is slightly enlarged, at first mainly in length. Testes and scrotum are further enlarged than in Stage II
Stage IV	G4	Penis is further enlarged, with growth in breadth and development of glans. Testes and scrotum are further enlarged than in Stage III; scrotal skin is darker than in earlier stages.
Stage V	G5	Genitalia are adult in size and shape.

Table 4.10 – Pubic Hair Stages for Males and Females

Tanner	SMR	
Stage I	PH1	Preadolescent: The vellus over the pubes is no further developed than the abdominal wall; for example, no pubic hair.

(Continued)

Table 4.10 – Pubic Hair Stages for Males and Females

Tanner	SMR	
Stage II	PH2	There is sparse growth of long slightly pigmented, downy hair, straight, or slightly curled, chiefly at the base of the penis or along the labia.
Stage III	PH3	The hair is considerably darker, coarser, and more curled. It spreads sparsely over the junction of the pubes.
Stage IV	PH4	Hair is now adult in type, but the area covered is still considerably smaller than in the adult. There is no spread to the medial surface of the thighs.
Stage V	PH5	The hair is adult in quantity and type with distribution of the horizontal (or classically feminine) pattern.
Stage VI	PH6	Spread is up the linear alba male escutcheon.

Note: This information is from: Tanner, JM: Growth of Adolescent, 2nd Edition, Oxford: Blackwell Scientific Publications, 1962, pp. 32-37)

Female Pubertal Development

Female sexual development begins with the appearance of a breast bud (85 percent) or pubic hair (15 percent) at a mean age of 11.2 years old. Menarche occurs at a mean age of 12.8 years old, generally at stage B4.

Male Pubertal Development

Male sexual development begins with testicular and scrotal enlargement (G2) at a mean age of 11.6 years old.

Table 4.11 – Onset of Puberty

Gender	Age
Females (B2 or PH2)	8.0 to 13.0 years (mean 11.2 years)
Males (G2)	9.0 to 13.4 years (mean 11.6 years)

Table 4.12 – Completion of Puberty

Gender	Age
Females (B5 or PH5)	12.4 to 16.8 years (mean 14.5 and 14.6)
Males (G5 or PH5)	13.5 to 17.9 years (mean 15.5 and 15.2)

Referral Standards

If the SMR is used, evaluation or referral to an appropriate specialist is indicated if the female patient has not reached SMR B2 by 13 years old or menarche by 16 years old.

For the male patient, evaluation or referral is indicated if SMR G2 is not reached by 13.5 years old.

HIV Testing

Common HIV tests use protein products of the virus to detect antibodies produced by the infected host. The two antibody tests used most commonly are:

- Enzyme-linked immunosorbent assay (ELISA)
- Western Blot

These tests are not 100 percent sensitive and require the production of antibody by the host and the absence of cross-reaching antibodies. Newer methodologies have been developed to divide HIV-1 tests into several groups:

- Virus culture techniques (PBMC coculture for HIV-1 isolation, quantitative cell culture, quantitative plasma culture)
- Antibody detection tests
- Antigen detection tests
- Viral genome amplification tests
- Immune function tests

False positive ELISA reactions generally result from cross-reaching antibodies such as those against class II human leukocyte antigens that are most often observed in multiparous women or in a person who has received multiple units of transfused blood. A common misconception is that a false positive ELISA will always be corrected by the confirmatory Western Blot test.

The most important parameter when interpreting HIV tests is the positive predictive value. The probability of a positive test result occurring in a truly infected individual is critically dependent on the prevalence of HIV infection of the population tested. In testing HIV drug users from a major U.S. city in which the seroprevalence is 50 percent, the positive predictive value would approach 100 percent. Conversely, in screening female schoolteachers from a rural area where the seroprevalence is 0.01 percent, 50 percent of the women testing positive would have a false positive result. The likelihood of two false negative tests (ELISA and Western Blot) is very low, even in areas where seroprevalence is low.

STD Screening

All sexually active adolescents must be considered at high risk for most sexually transmitted diseases (STDs). Factors that increase risk include the following:

- Unprotected sexual intercourse
- Multiple sexual partners
- Younger age, particularly when sexual debut occurs closer to the age of menarche
- History of STD

At least 50 percent of females with chlamydia or gonorrhea infections are asymptomatic, but at high risk for ascending infections (pelvic inflammatory disease). It is estimated that about six percent of sexually active adolescent males have asymptomatic chlamydia infections.

After reviewing data on the relation between curable STDs and the risk for sexual transmission of HIV, the Advisory Committee for HIV and STD Prevention (ACHSP) recommends early detection and treatment of other STDs as an effective strategy for preventing sexually transmitted HIV infection.

Specific Tests

The most sensitive and specific tests for chlamydia and gonorrhea are those involving DNA or RNA amplification (ligase chain reaction/LCR and polymerase chain reaction/PCR). They have the ability to detect both symptomatic and asymptomatic infections in males and females using urine (not clean voided) or direct swabbing of the endocervix or endourethra. Their greatest advantage appears to be among the asymptomatic individual because no invasive procedure is required. Informed consent must be obtained from the individual. These tests are not an acceptable or reliable way to determine if an adolescent is sexually active.

Cultures detect symptomatic and asymptomatic infections with gonorrhea and chlamydia. Samples must be obtained from the endocervix or endourethra. Culture of urine for these organisms is unsatisfactory.

Antigen detection (ELISA or direct fluorescent antibody) for chlamydia or gonorrhea is less sensitive than other methods.

Asymptomatic pyuria (WBC) can be detected using dipsticks for leukocyte esterase. Among sexually active adolescents, the likelihood of infection with an STD is increased when leukocyte esterase is detected. Subsequent evaluation to identify the etiology of the pyuria is indicated. Chlamydia urethritis must be considered when leukocyte esterase is identified in the urine of adolescent males.

Pelvic Exams

Sexually active adolescents should be considered at risk for abnormal cervical cytology because they are likely to have multiple sexual partners and because it appears that early age of intercourse increases the risk for infection with human papillomavirus. Screening at yearly intervals is recommended through adolescence.

Additional Codes

Additional codes that a provider can indicate on the claim for a HealthWatch/EPSDT visit are listed in Table 4.13.

Table 4.13 – Additional Codes

Code	Code Definition
87076	GC culture
86592	VDRL
87110	Chlamydia
88150	PAP Smear

Substance Abuse Screening

Urine testing to establish drug abuse seems a tempting and objective means of overcoming the problems of denial, unreliable histories, and the less-than-clear-cut signs and symptoms. However, there are problems of sensitivity and specificity in urine screens. False negatives occur because of innocent confounding substances. The physician's role in substance abuse screening, through obtaining a history of the patient, is identification and referral.

Lead Screening

The OMPP wants to ensure that all IHCP children between nine months and six years old are tested for lead poisoning and that children with elevated lead levels are identified and given the recommended follow-up treatment.

ISDH, through the ICLPPP, monitors lead poisoning in Indiana's children. ICLPPP has identified the following four steps to a successful lead poisoning prevention program:

- Early identification of children with excessive lead absorption through screening programs
- Treatment of children with abnormal blood lead levels
- Prompt termination of further excessive lead exposure (environmental investigation and abatement)
- Intensive parent and public education about lead poisoning

OMPP recommends that blood samples drawn for lead screening labs be sent to the ICLPPP to ensure that testing is done on Atomic Absorption Spectrophotometers (AAS) and to ensure that the results are known to the ICLPPP. As a free service to the provider, the ICLPPP provides the medical supplies, mailing container, and postage to return the sample to the ICLPPP laboratories. The following are the three ICLPPP laboratories:

- Vanderburgh County Department of Health
- Marion County Department of Health
- Indiana State Department of Health, located in Marion County

To find out where to send blood samples, and for information on the ICLPPP contact ICLPPP at (317) 233-1250, a local Health Department, or the Indiana Family Helpline at 1-800-433-0746.

Blood lead screening should initially be completed at the nine-month or 12-month visit and again at the 24-month visit. If high risk warrants it, blood lead screening should be initiated at the six-month visit. Subsequent screening should be done for at risk patients.

Lead poisoning is preventable. The key to successful prevention is early identification through blood lead testing. Children from nine months to six years are at greatest risk for elevated blood lead levels. In the initial stages of lead poisoning, a child could have an elevated blood lead level and show no symptoms of lead poisoning. The earliest symptoms include loss of appetite, headache, listlessness, irritability, and occasional vomiting. Later symptoms include continued vomiting, coma, brain damage, ataxia, clumsiness, weakness, abdominal pain, constipation, persistent vomiting, and kidney damage. Lead poisoning may cause anemia, permanent brain damage, learning disorders, loss of balance, kidney damage, blindness, hearing loss, seizures, coma, and death.

Lead poisoning is caused by ingestion and inhalation of common environmental lead sources. Ingestion is the principal route and inhalation is the second major route of lead absorption in children. Lead (except for certain organic lead compounds, such as tetraethyl lead) is not absorbed through the skin.

The following items place a child at risk for lead poisoning:

- Children with high incidence of hand-to-mouth activity, such as thumb sucking or nail biting
- Children with a history of Pica (a medical disorder characterized by a craving for nonfood items such as peeling paint, dirt, cigarette butts, and so forth)
- Children living in housing constructed **prior to 1978** may be exposed to lead pipes or lead-based paints

- Children living in or frequently visiting poorly maintained housing units constructed prior to the 1960s or who are exposed to other hazardous lead sources (such as, children of lead industrial workers)
- Children living in older homes that are being restored
- Children with poor nutritional status (increased fat, decreased calcium, iron, and other nutrients) are predisposed to enhance lead absorption in the intestines
- Children with a previously elevated blood lead level
- Children with signs and symptoms of lead poisoning

Sources of lead include:

- Painted household surfaces such as cribs, window sills, toys, doors, radiators, or fallen paint chips, flaking areas, and holes in the walls
- Lead water pipes
- Soil, dirt, and dust inside and outside a dwelling
- Imported brands of plastic mini-blinds
- Paper, newsprint, magazine pages, and metallic wrapping paper
- Playground equipment with chipped lead-based paint
- Water wells
- Industrial crayons, batteries, rubber, electronic devices, printed material (yellow and orange inks or oil colors may contain lead chromate), cans, varnishes, shellac, and paints on containers
- Unglazed food containers or pottery that have been lead glazed, lead alloyed, plated, or soldered
- Fungicides, insecticides, cosmetics, and various medications can contain lead carbonate
- Cigarette butts, decorative candle wicks, and matches can contain lead acetate
- Burning painted lumber and battery casings put lead in the air
- Folk remedies (for example, greta and azarcon used to treat diarrhea or gastrointestinal upset) can contain substantial amounts of lead

Anticipatory Guidance Regarding Lead Poisoning for Pregnant Women and Children Who Are Six Years Old or Younger

Pamphlets for use in offices, *Lead - Is Your Child at Risk?,* can be obtained from the ISDH by calling the Family Helpline at 1-800-433-0746.

Interpretation of Blood Lead Test Results and Follow-up Activities

Classification of the child is based on blood lead concentration.

Table 4.14 - Blood Lead Concentration

Class	Blood Lead Concentration (ug/dl)	Comment
I	< or = 9	A child in Class I is not considered to be lead-poisoned.

(Continued)

Table 4.14 - Blood Lead Concentration

Class	Blood Lead Concentration (ug/dl)	Comment
IIA	10-14	A child in Class IIA may need to be rescreened more frequently.
IIB	15-19	A child in Class IIB should receive nutritional and educational intervention and be rescreened within one month. If the blood lead level persists in this range, environmental investigation and intervention should be done.
III	20-44	A child in Class III should receive environmental evaluation, remediation and a medical evaluation. Such a child may need pharmacologic treatment of lead poisoning. The child should be rescreened within one week.
IV	45-69	A child in Class IV will need both medical and environmental interventions, including chelation therapy within 48 hours.
V	> or = 70	A child with Class V lead poisoning is a **medical emergency.** Medical and environmental management must begin **immediately**.

Newborn Screening

Newborn screenings are tests to be given at the earliest feasible time for the detection of the following disorders:

- Phenylketonuria
- Hypothyroidism
- Hemoglobinopathies, including sickle cell anemia
- Galactosemia
- Maple Syrup urine disease
- Homocystinuria
- Inborn errors of metabolism that resulting in mental retardation
- Congenital adrenal hyperplasia
- Biotinidase deficiency
- Disorders detected by tandem mass spectrometry or other technologies with the same or greater detection capabilities as tandem mass spectrometry, if the state determines that the technology is available for use by a laboratory designated under the applicable Indiana law

All blood samples are collected by the hospital on a filter paper card that must also contain information to identify the infant, the infant's physician as provided by the mother, the time of birth, the time of the first feeding, and time of the blood draw. The blood sample is sent to the Indiana University (IU) laboratory. IU is contracted by the ISDH to perform the laboratory analysis for newborn screening. There is a charge of $28.50 from the IU laboratory to the hospital for the initial test, but **if a retest is needed there is no additional charge** by the IU laboratory. If the IU lab requests further testing in the form of serum or whole blood collection, that testing is provided at no charge. The IU laboratory will indicate in the letter to the physician whether additional testing of serum or whole blood is indicated.

IHCP providers using laboratories other than the IU laboratory to perform newborn screening analysis should discontinue this practice immediately. Use of laboratories other than IU, increases

newborn screen costs unnecessarily. To ensure that the IU laboratory performs all newborn screening, all newborn screening should be coordinated through the ISDH. Providers must determine whether valid newborn screening test results have been obtained for the infant. **Laboratory results can be obtained by calling IU Laboratory at (317) 274-2231 or 1-800-245-9137**. If a valid test has been obtained for the infant and the test results were normal, no further testing is required. The newborn screening process is complete.

If a rescreen is needed because the first screen was invalid, or if additional testing of serums is needed because test results were abnormal, or if there is no record that newborn screening was done, providers should call ISDH at 1-800-761-1271, extension 1254, to work out the best method of accomplishing newborn screening. Generally, ISDH recommends that the infant be taken back to the birth hospital to have that hospital perform newborn screening or rescreening. However, providers should consult with ISDH on how best to proceed with newborn screening when there is an invalid or abnormal test. If additional information is needed, contact the Maternal and Child Health Division at (317) 233-1254 or 1-800-761-1271, extension 1254.

Because newborns can be released from hospitals prior to the 48 hours needed to obtain valid newborn screen results, an increasing number of newborns require a second screen. Families are generally asked to bring the newborn back to the birth hospital as an outpatient or the hospital requests that a nurse makes a follow up visit to obtain the sample for newborn screening. In either case there is a potential that the hospital could bill the IHCP separately for newborn screening that is already included in the DRG that the IHCP pays for the newborn hospitalization.

Therefore, effective May 1, 1995, hospitals are not permitted to bill the IHCP separately for newborn screenings. There are occasions when hospitals are requested to perform newborn screening for newborns born in another Indiana hospital. For example, when distance precludes a trip to the birth hospital, the infant should be taken to the nearest hospital with birthing facilities so that newborn screening can be completed. To prevent the second hospital from being charged by the IU laboratory for the second screen, the hospital must indicate on the filter paper card, in the space provided, the name of the birth hospital and the submitting hospital. The IU laboratory attempts to match the infant's second screen with the first screen so that the hospital is not charged. If the infant's name or birth date has been changed, the original name and date of birth must be included in the information sent to the IU lab to facilitate a match.

IHCP providers who deliver newborns at locations other than in a hospital can use code X3068 to bill the $28.50 charge from the IU laboratory for an initial newborn screening until December 31, 2004.

> *Note: Effective January 1, 2004, X3068 can no longer be used. IHCP provider bulletin BT200352 provides additional information about this change.*

Newborn screening results must be recorded in the patient record for infants younger than one year old.

Sickle Cell Anemia

Sickle cell disease is an inherited disorder of the red blood cells. Approximately one in 375 African American children has sickle cell disease. Other groups at risk for sickle cell include Hispanic Americans from the Caribbean, Central America, and parts of South America, and individuals from Turkey, Greece, Italy, the Middle East, or East India. Children born with sickle cell anemia have increased susceptibility to severe bacterial infection that can lead to meningitis, pneumonia, or septicemia. Such infections are a major cause of death among these children, especially those under five years old.

Early detection of sickle cell is important since oral prophylactic penicillin should be started by two-months old to prevent life-threatening infections. Children with sickle cell should be immunized as recommended by the AAP immunization schedule. They should also receive pneumococcal vaccine at two years old.

For more information about sickle cell anemia, contact the Family Helpline at 1-800-433-0746, or the Riley Hospital for Children Sickle Cell Program at (317) 274-2143 or 1-800-238-8399.

Tuberculosis

Information published by the AAP indicates that the most reliable tuberculosis control program is based on aggressive, expedient contact investigations, rather than routine skin test screening. The AAP recommends that all routine pediatric health care evaluations include assessment of risk of exposure to tuberculosis.

> *Note: Only children deemed to have increased risk of exposure to persons with tuberculosis should be considered for tuberculin (Mantoux) skin testing.*

The frequency of such skin testing should be according to the degree of risk of acquiring tuberculosis infection, as detailed below. Routine tuberculin skin testing of children with no risk factors residing in low prevalence communities is not indicated.

Children for whom immediate skin testing is indicated:

- Children with contacts to persons with confirmed or suspected infectious tuberculosis, including contact to family members or associates in jail or prison in the last five years
- Children with radiographic or clinical findings suggesting tuberculosis
- Children immigrating from endemic areas, such as, Asia, Africa, the Middle East, and Latin America
- Children with travel histories to endemic countries or significant contact with indigenous persons from such countries

Children who should be tested annually for tuberculosis:

- Children infected with HIV
- Incarcerated adolescents

Children who should be tested every two to three years:

- Children exposed to the following individuals who are HIV-infected: homeless residents of nursing homes, institutionalized adolescents or adults, users of illicit drugs, incarcerated adolescents or adults, and migrant farm workers.

Children who have no risk factors but who reside in high prevalence regions and children whose histories for risk factors are incomplete or unreliable should be considered for tuberculin (Mantoux) skin testing at four to six years old and 11 to 16 years old. The decision to test should be based on the local epidemiology of tuberculosis in conjunction with advice from regional tuberculosis control officials.

Family investigation is indicated whenever a tuberculin skin test result of a parent converts from negative to positive (indicating recent infection). Children of health care workers are not at increased risk of acquiring tuberculosis infection unless the workers tuberculin skin test results convert to positive or the workers have diagnoses of tuberculosis disease.

The skin test interpretation guidelines for indurations of five, 10, and 15mm in diameter remain appropriate for decisions about contact investigations, tuberculosis control measures, and preventive therapy.

Iron Deficiency Anemia

The purpose of screening for anemia is to uncover correctable nutritional anemia such as iron deficiency anemia.

Standards for Further Evaluation

Diagnosis of anemia should be based on the doctor's evaluation of the child and a blood test. Children with 10 grams of hemoglobin or less (or a hematocrit of 30 percent or less) should be further evaluated for anemia.

Even though 10 grams can represent the lower limit of normal for most of childhood, in early infancy and adolescence these levels should be higher. Red cell mass is strongly influenced by the levels of circulating androgens. Adolescents do not achieve the adult red cell mass until SMR 4-5.

For providers who use charts to evaluate hemoglobin or hematocrit normals it should be emphasized that average or mean Hb/B1 for age is not the level to determine anemia, but rather two standard deviations below the mean value.

Table 4.15 depicts the mean hematologic values for full-term infants, children, and adults and Table 4.16 provides the mean hematologic values for low-birth-weight infants.

Table 4.15 – Mean Hematologic Values For Full-Term Infants, Children, And Adults*

Age	Hemoglobin (g/dl)	Hematocrit (%)	RBC 4 (10/UL)	MCV 3 (um)	MCH (pg)	MCHC (g/dl)
Birth (cord blood)	1.7 ± 1.8	52.0 ± 5	4.64 ± 0.5	113 ± 6	37 ± 2	33 ± 1
1 day	19.4 ± 2.1	58.0 ± 7	5.30 ±0.5	110 ± 6	37 ± 2	33 ± 1
2-6 days	19.8 ± 2.4	66.0 ± 8	5.40 ± 0.7	122 ± 14	37 ± 4	30 ± 3
14-23 days	15.7 ± 1.5	52.0 ± 5	4.92 ± 0.6	106 ± 11	32 ± 3	30 ± 2
24-37 days	14.1 ± 1.9	45.0 ± 7	4.35 ± 0.6	104 ± 11	32 ± 3	31 ± 3
40-50 days	12.8 ± 1.9	42.0 ± 6	4.10 ± 0.5	103 ± 11	31 ± 3	30 ± 2
2-2.5 months	11.4 ± 1.1	38.0 ± 4	3.75 ± 0.5	101 ± 10	30 ± 3	30 ± 2
3-3.5 months	11.2 ± 0.8	37.0 ± 3	3.88 ± 0.4	95 ± 9	29 ± 3	30 ± 2
5-7 months	11.5 ± 0.7	38.0 ± 3	4.21 ± 0.5	91 ± 9	27 ± 3	30 ± 2
8-10 months	11.7 ± 0.6	39.0 ± 2	4.35 ± 0.4	90 ± 8	27 ± 3	30 ± 1
11-13.5 months	11.9 ± 0.6	39.0 ± 2	4.44 ± 0.4	88 ± 7	27 ± 2	30 ± 1
1.5-3 years	11.8 ± 0.5	39.0 ± 2	4.45 ± 0.4	87 ± 7	27 ± 2	30 ± 2
5 years	12.7 ± 10	37.0 ± 3	4.65 ± 0.5	80 ± 4	27 ± 2	34 ± 1
10 years	13.2 ± 1.2	39.0 ± 3	4.80 ± 0.5	81 ± 6	28 ± 3	34 ± 1
Men	15.5 ± 1.1	46.0 ± 3.1	5.11 ± 0.38	----------	----------	----------
Women	13.7 ± 1.0	40.9 ± 3	4.51 ± 0.36	----------	----------	----------
Men and women	----------	----------	----------	90.1 ± 4.8	30.2 ± 1.8	33.7 ± 1.1

** Mean + or - 1 SD*

Note: This information is from Johnson TR "How Growing Up Can Alter Lab Values in Pediatric Laboratory Medicine." Diag Med (Special Issue) 1982, 5 13-18.

Table 4.16 – Mean Hematologic Values For Low-Birth-Weight Infants*

Weight and Gestational Age at Birth	Age of Testing	Hemoglobin (g/dl)	Hematocrit (%)	Reticulocytes
<1.500 g. 28-32 weeks	3 days 1 week 2 weeks 3 weeks 4 weeks 6 weeks 8 weeks 10 weeks	17.5 ± 1.5 15.5 ± 1.5 13.5 ± 1.1 11.5 ± 1.0 10.0 ± 0.9 8.5 ± 0.5 8.5 ± 0.5 9.0 ± 0.5	54 ± 5 48 ± 5 42 ± 4 35 ± 4 30 ± 3 25 ± 2 25 ± 2 28 ±3	8.0 ± 3.5 3.0 ± 1.0 3.0 ± 1.0 ------- 6.0 ± 2.0 11.0 ± 3.5 8.5 ± 3.5 7.0 ± 3.0
1.500-2.000 g. 32–36 weeks	3 days 1 week 2 weeks 3 weeks 4 weeks 6 weeks 8 weeks 10 weeks	19.0 ± 2.0 16.5 ± 1.5 14.5 ± 1.1 13.0 ± 1.1 12.0 ± 1.0 9.5 ± 0.8 9.5 ± 0.5 9.5 ± 0.5	59 ± 6 51 ± 5 44 ± 5 39 ± 4 36 ± 4 28 ± 3 28 ± 3 29 ± 3	6.0 ± 2.0 3.0 ± 1.0 2.5 ± 1.0 ---------- 3.0 ± 1.0 6.0 ± 2.0 5.0 ± 1.5 4.5 ± 1.5
2.000-2.500 g. 36-40 weeks	3 days 1 week 2 weeks 3 weeks 4 weeks 6 weeks 8 weeks 10 weeks	19.0 ± 2.0 16.5 ± 1.6 15.0 ± 1.5 14.0 ± 1.1 12.5 ± 1.0 10.5 ± 0.9 10.5 ± 0.9 11.0 ± 1.0	59 ± 6 51 ± 5 45 ± 5 43 ± 4 37 ± 4 31 ± 3 31 ± 3 33 ± 3	4.0 ± 1.0 3.0 ± 1.0 2.5 ± 1.0 ---------- 2.0 ± 1.0 3.0 ± 1.0 3.0 ± 1.0 3.0 ± 1.0

**Mean + or - 1 SD*

Note: This information is from Johnson TR, How Growing Up Can Alter Lab Values in Pediatric Laboratory Medicine., Diag Med (Special Issue) 1982, 5 13-18.

Urinalysis Screening

Examination of urine is a valuable and relatively simple office procedure that can be used by a provider to assess the status of renal function and sterility of the urinary tract. Urinalysis can also

provide clues of more generalized diseases. All urine examinations require properly collected, clean caught mid-stream specimens. Urinalyses of other than clean-caught specimens are of little value.

Urinary Albumin and Sugar Testing and Referral Standards

> *Note: Tests for urinary albumin and sugar must be done on every child routinely at five years old or at every screen, if clinically indicated or not done previously.*

Dipsticks are acceptable for testing.

A positive test must be suitably followed up or referred for further care. A 1+ albumin (or trace) with no symptoms need not be referred, as it is not an unusual finding.

Bacteriuria Testing and Referral Standards

Screening is recommended if there are symptoms related to possible urinary tract infections.

Anticipatory Guidance

At each screening visit, provide age-appropriate anticipatory guidance concerning such topics as the following:

- Auto safety – Car seats, seat belts, air bags, positioning young or lightweight children in the backseat
- Recreational safety – Helmets and protective padding, playground equipment
- Home hazards – Poisons, accidental drownings, weapons, matches and lighters, staying at home alone, use of detectors for smoke, radon gas, and carbon monoxide
- Exposure to sun and secondhand smoke
- Alcohol and tobacco use
- Substance abuse
- Adequate sleep, exercise and nutrition, including eating habits and disorders
- Sexual activity
- Peer pressure

Bright Futures, Guidelines for Health Supervision of Infants, Children, and Adolescents, published by the U.S. Department of Health and Human Services, Health Resources and Services Administration (HRSA), contains recommendations about anticipatory guidance. *Bright Futures* recommendations are consistent with those of the American Academy of Pediatrics.

Appendix A: Periodicity and Screening Schedule

Every child and family is unique; therefore, this periodicity and screening schedule has been designed as a preventive health care plan for children with the absence of any significant health problems and who are growing and developing in satisfactory fashion. This schedule can be adjusted to meet the health care needs of specific patients.

This periodicity schedule reflects recommendations of the AAP and those of the Medicaid Clinical Advisory Committee. It is meant to be a guide for IHCP providers participating in the HealthWatch/EPSDT Program. This program emphasizes the importance of early and periodic screening for specific conditions and the need for continued diagnosis and treatment of conditions and symptoms identified by practicing professionals through the use of this schedule.

The periodicity schedule is also published in *405 IAC 5-15-8*.

	INFANCY[3]								**EARLY CHILDHOOD[3]**					**MIDDLE CHILDHOOD[3]**				**ADOLESCENCE[3]**				
AGE[4]	NEWBORN[1]	2-4d[2]	By 1mo	2mo	4mo	6mo	9mo	12mo	15mo	18mo	24mo	3y	4y	5y	6y	8y	10y	12y	14y	16y	18y	20y
HISTORY:INITIAL/INTERVAL	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
MEASUREMENTS																						
Height and Weight	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Head Circumference	●	●	●	●	●	●	●	●	●	●	●											
Blood Pressure												●	●	●	●	●	●	●	●	●	●	●
SENSORY SCREENING																						
Vision[5]	S	S	S	S	S	S	S	S	S	S	S	O_5	O	O	S	S	O	O	S	S	O	S
Hearing[5]	S/R	S	S	S	S	S	S	◄	─	─	─	─	O	O	S	S	O_6	O_6	S	S	O_6	S
DEVELOPMENTAL/ BEHAVIOR ASSESSMENT	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
PHYSICAL EXAMINATION[8]	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
PROCEDURES - GENERAL																						
Immunization[9]	●	─	►	●	●	●		◄	●	►			◄	●	►			●	►			
Lead Screening[10]							●	►			●	R	R	R	R	R	R	R	R	R	R	R
Hematocrit or Hemoglobin			◄	─	─	─	●				●			●				◄	~~11~~	─	►	
Urinalysis														●				◄	~~12~~	─	►	
PROCEDURES - PATIENTS AT RISK																						
Tuberculin Test[13]								R	R	R	R	R	R	R	R	R	R	R	R	R	R	R
Sickle Cell Test[14]	●																					
Drug/HIV Testing[15]	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R
STD Screening[16]																		R	R	R	R	R
Pelvic Exam																		R	R	◄	~~17~~ ►	R
ANTICIPATORY GUIDANCE	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Injury Prevention	●			●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Dental Referral								◄	─	─	●	●	●	●	●	●	●	●	●	●	●	●
Dental Observation[18]	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●	●
Newborn Infant Screen[19]	◄	►																				

Please Consult the EPSDT-HealthWatch Program Provider Manual for immunization schedules and risk factor definitions

Key: ● = to be performed **R** = to be performed on patient at risk **S** = subjective, by history **O** = objective, by a standard testing method

●──► = range during which a service may be provided, with the dot or number indicating the preferred age

Figure A. 1 – Periodicity and Screening Schedule per the IAC Supplement for 2000

Table A.1 – Periodicity and Screening Schedule

Item	Description
1	Breast-feeding encouraged and supported.
2	For newborns discharged in less than 48 hours after delivery.
3	Developmental, psychosocial, and chronic disease issues for children and adolescents may require frequent counseling and treatment visits separate from preventive care visits.
4	If a child comes under care for the first time at any point on this schedule, or if any items are not accomplished at the suggested age, the schedule should be brought up to date at the earliest possible time.
5	If the patient is uncooperative, rescreen within six months. If screening results warrant, refer to vision or hearing specialist as appropriate.
6	Not to be duplicated if done in school system.
7	By history and appropriate physical examination: if suspicious, by specific objective developmental testing.
8	At each visit, a complete physical examination is essential, with infant totally unclothed, older children undressed and suitably draped.
9	According to the schedule currently recommended by the America Academy of Pediatrics. Every visit should be an opportunity to update and complete a child's immunizations.
10	Blood lead screening, as recommended by the AAP at indicated intervals and for patients at risk.
11	All menstruating adolescents should be screened.
12	A dipstick urinalysis for leukocytes for male and female adolescents.
13	Only children deemed to have increased risk of exposure to persons with tuberculosis should be considered for tuberculin (Mantoux) skin testing. The frequency of skin testing should be according to the degree of risk.
14	Should be performed one time only, when clinically indicated, or if not done in the newborn screen.
15	Should be done on newborns and annually for those at risk, with patient/parent consent.
16	All sexually active patients should be screened for STDs.
17	All sexually active females should have a pelvic examination. A pelvic exam and routine pap smear should be offered between 18 and 21 years old as part of an active preventive health plan.
18	Dental referral may include fluoride treatments.
19	Must be done 48 hours after birth.

Every child and family is unique, therefore this Periodicity and Screening Schedule has been designed as a preventive health care plan for children with the absence of any significant health problems who are growing and developing in satisfactory fashion. This Schedule may need to be adjusted to meet the health care needs of specific patients.

This Periodicity Schedule reflects recommendations of the American Academy of Pediatrics along with those of the Hoosier Healthwise Clinical Advisory Committee and is meant to be a guide for Indiana Medicaid Providers participating in the EPSDT - HealthWatch Program. This program emphasizes the importance of early and periodic screening for specific conditions, as outlined below, and the need for continued diagnosis and treatment of conditions and symptoms identified by practicing professionals through the use of this Schedule.

	INFANCY[3]								EARLY CHILDHOOD[3]					MIDDLE CHILDHOOD[3]				ADOLESCENCE[3]				
AGE[4]	NEWBORN[1]	2-4d[2]	By 1mo	2mo	4mo	6mo	9mo	12mo	15mo	18mo	24mo	3y	4y	5y	6y	8y	10y	12y	14y	16y	18y	20y
HISTORY:INITIAL/INTERVAL	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
MEASUREMENTS																						
Height and Weight	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Head Circumference	•	•	•	•	•	•	•	•	•	•	•											
Blood Pressure												•	•	•	•	•	•	•	•	•	•	•
SENSORY SCREENING																						
Vision[5]	S	S	S	S	S	S	S	S	S	S	S	O_6	O	O	S	S	O	O	S	S	O	S
Hearing[5]	S/R	S	S	S	S	S	S	◄	►	►	►	►	O	O	S	S	O_6	O_6	S	S	O_6	S
DEVELOPMENTAL/ BEHAVIOR ASSESSMENT[7]	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
PHYSICAL EXAMINATION[8]	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
PROCEDURES - GENERAL																						
Immunization[9]	• ►	►	►	•	•	•	◄	►	• ►	►	►	►	◄	• ►	►	►	►	• ►	►	►	►	►
Lead Screening[10]	►	►	►	►	►	►	• ►	►	►	►	•	R	R	R	R	R	R	R	R	R	R	R
Hematocrit or Hemoglobin	►	►	◄	►	►	►	•	►	►	►	•	►	►	•	►	►	►	◄ 11	►	►	►	►
Urinalysis	►	►	►	►	►	►	►	►	►	►	►	►	►	•	►	►	►	◄ 12	►	►	►	►
PROCEDURES - PATIENTS AT RISK																						
Tuberculin Test[13]	►	►	►	►	►	►	►	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R
Sickle Cell Test[14]	•	►	►	►	►	►	►	►	►	►	►	►	►	►	►	►	►	R	R	R	R	R
Drug/HIV Testing[15]	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R	R
STD Screening[16]	►	►	►	►	►	►	►	►	►	►	►	►	►	►	►	►	►	R	R	R	R	R
Pelvic Exam	►	►	►	►	►	►	►	►	►	►	►	►	►	►	►	►	►	R	R	R►	17	►R
ANTICIPATORY GUIDANCE	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Injury Prevention	•	►	►	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Dental Referral	►	►	►	►	►	►	◄	►	►	►	►	•	•	•	•	•	•	•	•	•	•	•
Dental Observation[18]	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•	•
Newborn Infant Screen[19]	◄	►	►	►	►	►	►	►	►	►	►	►	►	►	►	►	►	►	►	►	►	►

[1]Breastfeeding encouraged and supported.
[2]For newborns discharged in less than 48 hours after delivery.
[3]Developmental, psychosocial, and chronic disease issues for children and adolescents may require frequent counseling and treatment visits separate from preventive care visits.
[4]If a child comes under care for the first time at any point on this schedule, or if any items are not accomplished at the suggested age, the schedule should be brought up to date at the earliest possible time.
[5]If the patient is uncooperative, rescreen within six months. If objective vision methods indicate, refer to optometrist/ophthalmologist.
[6]Not to be duplicated if done in school system.
[7]By history and appropriate physical examination; if suspicious, by specific objective developmental testing.
[8]At each visit, a complete physical examination is essential, with infant totally unclothed, older child undressed and suitably draped.
[9]According to the schedule currently recommended by the American Academy of Pediatrics. Every visit should be an opportunity to update and complete a child's immunizations.
[10]Blood lead screening, as recommended by the AAP at indicated intervals and for patients at risk.
[11]All menstruating adolescents should be screened.
[12]A dipstick urinalysis for leukocytes for male and female adolescents.
[13]Only children deemed to have increased risk of exposure to persons with tuberculosis should be considered for tuberculin (Mantoux) skin testing. The frequency of skin testing should be according to the degree of risk.
[14]Should be performed one time only, when clinically indicated, or if not done in the newborn screen.
[15]Should be done on newborns and annually for those at risk, with patient/parent consent.
[16]All sexually active patients should be screened for sexually transmitted diseases (STDs).
[17]All sexually active females should have a pelvic examination. A pelvic exam and routine pap smear should be offered between the ages of 18 and 21 as part of an active preventive health plan.
[18]Dental referral may include flouride treatments.
[19]Must be done 48 hours after birth.

Please consult the EPSDT - HealthWatch Program Provider Manual for immunization schedules and risk factor definitions.

Key: • = to be performed R = to be performed on patients at risk S = subjective, by history O = objective, by a standard testing method
◄ ► = range during which a service may be provided, with the dot or number indicating the preferred age

Figure A.2 – Recommended Childhood Immunization Schedule

1. This schedule indicates the recommended ages for routine administration of currently licensed childhood vaccines, as of November 1, 2000, for children through 18 years old. Additional vaccines can be licensed and recommended during the year. Licensed combination vaccines can be used whenever any components of the combination are indicated and its other components are not contraindicated. Providers must consult the manufacturer's package inserts for detailed recommendations.

2. Infants born to HBsAg-negative mothers should receive the first dose of hepatitis B (Hep B) vaccine by age two months. The second dose should be at least one month after the first dose. The third dose should be administered at least four months after the first dose and at least two months after the second dose, but not before six months of age.

   Infants born to HBsAg-positive mothers should receive hepatitis B vaccine and 0.5ml hepatitis B immune globulin (HBIG) within 12 hours of birth at separate sites. The second dose is recommended at one to two months of age and the third dose at six months of age.

   Infants born to mothers whose HBsAg status is unknown should receive hepatitis B vaccine within 12 hours of birth. Maternal blood should be drawn at the time of delivery to determine the mother's HBsAg status; if the HBsAg test is positive, the infant should receive HBIG as soon as possible (no later than one week of age).

   All children and adolescents who have not been immunized against hepatitis B should begin the series during any visit. Special efforts should be made to immunize children who were born in or whose parents were born in areas of the world with moderate or high endemicity of hepatitis B virus infection.

3. The fourth dose of DTaP (diphtheria and tetanus toxoids and acellular pertussis vaccine) may be administered as early as 12 months old, provided six months have elapsed since the third dose and the child is unlikely to return at age 15-18 months. Td (tetanus and diphtheria toxoids) is recommended at 11-12 years old if at least five years have elapsed since the last dose of DTP, DTaP, or DT. Subsequent routine Td boosters are recommended every 10 years.

4. Three *Haemophilus influenzae* type B (Hib) conjugate vaccines are licensed for infant use. If PRP-OMP (PedvaxHIB® or ComVax® [Merck]) is administered at two and four months old, a dose at six months is not required. Because clinical studies in infants have demonstrated that using some combination products may induce a lower immune response to the Hib vaccine component, DTaP/Hib combination products should not be used for primary immunization in infants at two, four, or six months old, unless FDA-approved for these ages.

5. An all-IPV schedule is recommended for routine childhood polio vaccination in the United States. All children should receive four doses of IPV at two months, four months, six to 18 months, and four to six years old. Oral polio vaccine (OPV) should be used only in selected circumstances. (See *MMWR May 19, 2000/49(RR-5); 1-22*).

6. The heptavalent conjugate pneumococcal vaccine (PCV) is recommended for all children two to 23 months old. It also is recommended for certain children 24-59 months old (See *MMWR October 6, 2000/49(RR-9); 1-35*). The full AAFP Clinical Policy on Pneumococcal Conjugate Vaccine is available at www.aafp.org/policy/camp/24.html.

7. The second dose of measles, mumps, and rubella (MMR) vaccine is recommended routinely at four to six years old, but may be administered during any visit, provided at least four weeks have elapsed since receipt of the first dose and that both doses are administered beginning at or after 12 months old. Those who have not previously received the second dose should complete the schedule by the 11-12 year old visit.
8. Varicella (Var) vaccine is recommended at any visit on or after the first birthday for susceptible children, such as those who lack a reliable history of chickenpox (as judged by a health care provider) and who have not been immunized. Susceptible persons 13 years old and older should receive two doses, given at least four weeks apart.
9. Hepatitis A (Hep A) is shaded to indicate its recommended use in selected states or regions, and for certain high-risk groups; consult your local public health authority (See *MMWR October 1, 1999/48(RR-12); 1-37*).

For additional information about the vaccines listed above, please visit the National Immunization Program Web site at http://www.cdc.gov/nip/ or call the National Immunization Hotline at 1-800-232-2522 in English or 1-800-232-0233 in Spanish.

Full AAFP immunization policies can be found on the AAFP Web site at www.aafp.org/clinical.

Appendix B: Catch-Up Immunization Schedule

The catch-up immunization schedule for children who are identified as non-immunized at ages older than identified is the Periodicity and Immunization Schedule is provided in Figure B.1.

For Children and Adolescents Who Start Late or Who Are >1 Month Behind

Tables 1 and 2 give catch-up schedules and minimum intervals between doses for children who have delayed immunizations. There is no need to restart a vaccine series regardless of the time that has elapsed between doses. Use the chart appropriate for the child's age.

Table 1. Catch-up schedule for children age 4 months through 6 years

Dose One (Minimum Age)	Minimum Interval Between Doses			
	Dose One to Dose Two	Dose Two to Dose Three	Dose Three to Dose Four	Dose Four to Dose Five
DTaP (6 wks)	**4 weeks**	**4 weeks**	**6 months**	**6 months**[1]
IPV (6 wks)	**4 weeks**	**4 weeks**	**4 weeks**[2]	
HepB[3] (birth)	**4 weeks**	**8 weeks** (and 16 weeks after first dose)		
MMR (12 mos)	**4 weeks**[4]			
Varicella (12 mos)				
Hib[5] (6 wks)	**4 weeks:** if 1st dose given at age <12 mos **8 weeks (as final dose):** if 1st dose given at age 12-14 mos **No further doses needed:** if first dose given at age ≥15 mos	**4 weeks**[6]: if current age <12 mos **8 weeks (as final dose)**[6]: if current age ≥12 mos and 2nd dose given at age <15 mos **No further doses needed:** if previous dose given at age ≥15 mos	**8 weeks (as final dose):** this dose only necessary for children age 12 mos - 5 yrs who received 3 doses before age 12 mos	
PCV[7]: (6 wks)	**4 weeks:** if 1st dose given at age <12 mos and current age <24 mos **8 weeks (as final dose):** if 1st dose given at age ≥ 12 mos or current age 24-59 mos **No further doses needed:** for healthy children if 1st dose given at age ≥24 mos	**4 weeks:** if current age <12 mos **8 weeks (as final dose):** if current age ≥12 mos **No further doses needed:** for healthy children if previous dose given at age ≥24 mos	**8 weeks (as final dose):** this dose only necessary for children age 12 mos – 5 yrs who received 3 doses before age 12 mos	

Table 2. Catch-up schedule for children age 7 through 18 years

Minimum Interval Between Doses		
Dose One to Dose Two	Dose Two to Dose Three	Dose Three to Booster Dose
Td: 4weeks	**Td:** 6 months	**Td**[8]: **6 months:** if 1st dose given at age <12 mos and current age <11 yrs **5 years:** if 1st dose given at age ≥12 mos and 3rd dose given at age <7 yrs and current age ≥11 yrs **10 years:** if 3rd dose given at age ≥7 yrs
IPV[9]: 4 weeks	**IPV**[9]: 4 weeks	**IPV**[9]
HepB: 4 weeks	**HepB:** 8 weeks (and 16 weeks after first dose)	
MMR: 4 weeks		
Varicella[10]: 4 weeks		

1. **DTaP:** The fifth dose is not necessary if the fourth dose was given after the 4th birthday.
2. **IPV:** For children who received an all-IPV or all-OPV series, a fourth dose is not necessary if third dose was given at age ≥4 years. If both OPV and IPV were given as part of a series, a total of four doses should be given, regardless of the child's current age.
3. **HepB:** All children and adolescents who have not been immunized against hepatitis B should begin the hepatitis B vaccination series during any visit. Providers should make special efforts to immunize children who were born in, or whose parents were born in, areas of the world where hepatitis B virus infection is moderately or highly endemic.
4. **MMR:** The second dose of MMR is recommended routinely at age 4-6 years, but may be given earlier if desired.
5. **Hib:** Vaccine is not generally recommended for children age ≥5 years.
6. **Hib:** If current age <12 months and the first 2 doses were PRP-OMP (PedvaxHIB or ComVax), the third (and final) dose should be given at age 12-15 months and at least 8 weeks after the second dose.
7. **PCV:** Vaccine is not generally recommended for children age ≥5 years.
8. **Td:** For children age 7-10 years, the interval between the third and booster dose is determined by the age when the first dose was given. For adolescents age 11-18 years, the interval is determined by the age when the third dose was given.
9. **IPV:** Vaccine is not generally recommended for persons age ≥18 years.
10. **Varicella:** Give 2-dose series to all susceptible adolescents age ≥13 years.

Reporting Adverse Reactions
Report adverse reactions to vaccines through the federal Vaccine Adverse Event Reporting System. For information on reporting reactions following vaccines, please visit www.vaers.org or call the 24-hour national toll-free information line (800) 822-7967.

Disease Reporting
Report suspected cases of vaccine-preventable diseases to your state or local health department.

For additional information about vaccines, including precautions and contraindications for immunization and vaccine shortages, please visit the National Immunization Program Website at www.cdc.gov/nip or call the National Immunization Information Hotline at 800-232-2522 (English) or 800-232-0233 (Spanish).

B.1 – Catch-Up Immunization Schedule

Appendix C:Summary of HealthWatch/EPSDT Codes

Table C.1 – Diagnosis Codes

Diagnosis Code	Code Description
V20.2	Routine infant or child health check

Table C.2 – Visit Codes (Effective October 1, 1994)

Age	Initial Patient Exam	Established Patient Exam
Younger than one year	99381	99391
One to four years	99382	99392
Five to 11 years	99383	99393
12 to 17 years	99384	99394
18 to 20 years	99385	99395

Table C.3 – Immunization/Screens for all Providers

Code Type	Code Definition
80100	HIV/AIDS
81000	Urinalysis with microscopy
81002	Urinalysis without microscopy
86550	Sickle cell test
86580	TB Mantoux
90645	HIB, HBOC*
90647	HIB, PRP-OMP*
90648	HIB, PRP-T*
90669	Pneumoccocal conjugate, polyvalent*
90700	DtaP*
90701	DTP
90702	Tetanus-Diphtheria (DT)*
90707	MMR*
90712	Polio – OPV
90713	Polio – IPV*
90716	Varicella (chicken pox)*
90718	Tetanus-Diphtheria (adult) Td*
90720	DTP – HIB
90721	DTaP/HIB*
90737	Haemophilus Influenza B

(Continued)

Table C.3 – Immunization/Screens for all Providers

Code Type	Code Definition
90742	HBIG
90744	Hepatitis B, newborn to 11 years*
90745	Hepatitis B, 11 to 19 years*
90746	Hepatitis B, 20 years and older
90747	Hepatitis B, Dialysis or immunosuppressed, patient any age
90748	HEP B-Ped-HIB*
92551	Audiometry testing

**VFC - Available*

Table C.4 – Codes for Providers with No In-House Laboratories

Procedure Code	Code Description
36415	Venipuncture/finger Stick
99000	Conveyance fee to send samples to lab
99001	Conveyance fee from other than a physician's office

Table C.5 – Codes for Providers with In-House Laboratories

Procedure Code	Code Description
83655	Blood lead**
85013, 85014	Hematocrit
85018	Hemoglobin
85660	Sickle cell

*** Only when tested on an atomic absorption spectrophotometer (AAS)*

Table C.6 – Most Common Diagnosis Codes on HealthWatch/EPSDT Claims

Diagnosis Code Description	Diagnosis Code
Abdominal pain	789.0
Actinic skin (dermatosis)	702.0
Acute pharyngitis	462.0
Acute respiratory infection	465.9
Allergic rhinitis	477.0
Anemia unspecified	285.9
Arthritis	716.9
Asthma (extrinsic)	493.0
Atherosclerosis	414.0

(Continued)

Table C.6 – Most Common Diagnosis Codes on HealthWatch/EPSDT Claims

Diagnosis Code Description	Diagnosis Code
Blurred vision	368.8
Bronchitis	466.0
Chest pain	786.5
Congestive heart failure	428.0
Conjunctivitis	372.0
Constipation	564.0
Contact dermatitis	692.9
Contusion	924.9
COPD, NOS	496.0
Cough	786.2
Croup	464.4
Diabetes Mellitus	250.0
Eczema or dermatitis	692.9
Eustachian tube disorder	381.81
Feeding diff, newborn	779.3
Fever of unknown origin	780.6
Gastroenteritis	558.9
Head Lice	132.0
Heart Disease	429.9
Hyperlipidemia	272.1
Immunization	V06.0
Impaired hearing	389.9
Impaired vision (moderate)	369.74
Impetigo	684.0
Influenza vaccine	V04.8
Joint pain	719.9
Lead poisoning (paint – accidental)	E861.5
Mononucleosis	075.0
N&V	787.0
Need for prophylactic immunization	V05.9
Otitis media	382.9
Pharyngitis	462.0
Pneumonia	486.0
Prenatal care	V22.1
Purulent rhinitis	472.0
Reactive airway disease (RAD)	493.0
Seizure disorder	780.3
Sickle cell anemia	282.6

(Continued)

Table C.6 – Most Common Diagnosis Codes on HealthWatch/EPSDT Claims

Diagnosis Code Description	Diagnosis Code
Sinusitis	461.9
Sprain or strain	848.9
Strep pharyngitis	034.0
Tuberculosis	010.9
Upper respiratory infection	465.9
UTI	599.0
Vertigo NOS	780.4
Viral syndrome	079.9
Viral URI	519.8
Well child care	V20.2

Appendix D: Interpretation of Blood Lead Test Results

Interpretation of blood lead test results and follow-up of activities are grouped into different classes. Classification of the child is based on blood lead concentration are listed below.

Table D.1 – Blood Lead Concentration

Class	Blood Lead Concentration (ug/dl)	Comment
I	< or = 9	A child in Class I is not considered to be lead-poisoned
IIA	10-14	A child in Class IIA may need to be rescreened more frequently
IIB	15-19	A child in Class IIB should receive nutritional and educational intervention and be rescreened within one month. If the blood lead level persists in this range, environmental investigation and intervention should be done.
III	20-44	A child in Class III should receive environmental evaluation, remediation, and a medical evaluation. A child in this class may need pharmacologic treatment of lead poisoning. Rescreen the child within one week.
IV	45-69	A child in Class IV will need both medical and environmental interventions, including chelation therapy within 48 hours.
V	> or = 70	A child with Class V lead poisoning is a **medical emergency.** Medical and environmental management must begin **immediately**.

The OMPP encourages providers to work with the ICLPPP and submit blood lead samples to one of the following laboratories:

- Vanderburgh County Department of Health
- Marion County Department of Health
- Indiana State Department of Health, located in Marion County

To find out where to send blood samples and for information on the ICLPPP, contact a local health department or the Family Helpline at: 1-800-433-0746.

Appendix E: CMS-1500 Claim Form

PLEASE DO NOT STAPLE IIN THIS AREA

PICA

HEALTH INSURANCE CLAIM FORM

PICA

1. MEDICARE | MEDICAID | CHAMPUS | CHAMPVA | GROUP HEALTH PLAN | FECA BLK LUNG | OTHER
(Medicare #) [X] (Medicaid #) [ ] (Sponsor's SS [ ] (VA File [ ] (SSN or [ ] (SS [ ] (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1)
987654321199

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)
Infant, James

3. PATIENT'S BIRTH DATE MM DD YY | SEX
05 01 01 [X] M [ ] F

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED
Self [ ] Spous [ ] Chi [ ] Oth [ ]

7. INSURED'S ADDRESS (No., Street)

CITY | STATE

8. PATIENT STATUS
Single [ ] Marrie [ ] Oth [ ]
Employed [ ] Full-Time Student [ ] Part-Time Studen [ ]

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code)
( )

ZIP CODE | TELEPHONE (INCLUDE AREA CODE)
( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (CURRENT OR PREVIOUS) [ ] YES [ ] NO

a. INSURED'S DATE OF BIRTH MM DD YY | SEX

b. OTHER INSURED'S DATE OF BIRTH MM DD YY | SEX

b. AUTO ACCIDENT? [ ] YES [ ] NO PLACE (State)

b. EMPLOYER'S NAME OR SCHOOL NAME

c. EMPLOYER'S NAME OR SCHOOL NAME

c. OTHER ACCIDENT? [ ] YES [ ] NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? [ ] YES [ ] NO *If yes, return to and complete item 9 a-d.*

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.
SIGNED _____ DATE

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
SIGNED _____

14. DATE OF CURRENT: ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY (LMP) MM DD YY

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? [ ] YES [ ] NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)
1. V202
2.

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A DATE(S) OF SERVICE From MM DD YY	To MM DD YY	Place of Service	B Type of Service	C PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	D DIAGNOSIS CODE	E $CHARGES	F DAYS OR UNITS	EPSDT Family Plan	G EMG	J COB	H RESERVED FOR LOCAL USE	I K
10 01 01	10 01 01	11		99391		1	50 00	1				123456789A	
10 01 01	10 01 01	11		90712		1	10 00	1				123456789A	
10 01 01	10 01 01	11		90720		1	22 00	1				123456789A	
10 01 01	10 01 01	11		90744		1	35 00	1				123456789A	

25. FEDERAL TAX I.D. NUMBER SSN EIN

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims see back) [ ] YES [ ] NO

28. TOTAL CHARGE $ 117 00

29. AMOUNT PAID $

30. BALANC $ 117 00

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof)
A. Physician 10/21/01
SIGNED _____ DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ZIP CODE & PHONE #
PIN# **123333444A**

PLEASE PRINT OR TYPE

FORM HCFA-1500 (12-90)
FORM OWCF-1500 FORM RRB-1500

Figure D.1 – CMS-1500 Form

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Appendix F: Other Children's Programs in Indiana

Health-Related Programs

For information about the programs listed in this Appendix, please call the Indiana Family Helpline at 1-800-433-0746.

Indiana Health Coverage Insurance Programs

Hoosier Healthwise (Medicaid and CHIP)

Medicaid

Any recipient of Temporary Assistance for Needy Families (TANF) is eligible for Medicaid. In addition, pregnant women, infants, and children one to 18 years of age with family incomes under 150 percent of the federal poverty level (FPL) are eligible for Medicaid. Claims are submitted to the appropriate IHCP delivery system.

CHIP

The Children's Health Insurance Program or CHIP is the State's program under *Title XXI* of the *Social Security Act* to provide health care coverage for children from birth through 18 years of age. Claims for services are submitted to the appropriate IHCP delivery system.

HealthWatch (EPSDT)

HealthWatch is the federally mandated Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program for Indiana Medicaid members younger than 21 years old. All IHCP-covered preventive and treatment services are provided, as well as other treatment services that are determined to be medically necessary by the EPSDT screening provider and prior authorized as required. Claims are submitted to the IHCP delivery system in which the member is enrolled.

Medicaid Select

The OMPP was directed by the Indiana State Legislature (*IC 12-15-12*) to amend the State's Medicaid 1915 (b) waiver to include the aged, blind, and disabled in a managed care program. The OMPP submitted this waiver amendment to the CMS.

The new managed care program, *Medicaid Select*, began with the PCCM delivery system in 2003. RBMC will be added after January 1, 2004. Claims are submitted to the appropriate IHCP delivery system. IHCP provider bulletin *BT200257*, published November 19, 2002, and the www.indianamedicaid.com Web site include more information about *Medicaid Select*.

Mental Health Rehabilitation Option

Mental Health Rehabilitation Option (MRO) services are clinical mental health services provided to individuals, families, or groups of people who live in the community and who need care intermittently for an emotional disturbance or mental illness. IHCP reimbursement is available for mental health rehabilitation option services when those services are provided by a mental health center that is enrolled as an IHCP provider and complies with applicable federal, state, and local laws concerning operation of community mental health centers.

IHCP Waiver Program

IHCP Waiver Program applicants must contact the Area Agency on Aging (AAA) that serves their county of residence, and the AAA case manager completes the intake and application forms within 15 days. The applicant is then put on a waiting list. When the Medicaid Waiver Unit informs the case manager that a slot is open, the manager notifies the applicant within three days. The case manager schedules an evaluation and physical examination within seven days of the notification date.

Providers are enrolled with the IHCP and claims are processed through the IHCP.

Prenatal Care Coordination

Prenatal care coordination services are *targeted case management services* for pregnant women. Care coordination is an active, ongoing process of assisting the individual with identification, access, and use of community resources and coordination of services to meet individual needs. This includes locating service sources, making appointments for services, arranging transportation to services, and following up to verify appointments or reschedule appointments for women in the IHCP whose pregnancies are at risk for low birth weight or poor pregnancy outcome.

Pregnant women who are identified by the *Prenatal Risk Assessment* form as high-risk patients because of medical or psychosocial conditions may also receive pregnancy care coordination services through the IHCP.

HIV Care Coordination

HIV and AIDS care coordination is a specialized form of case management for members with HIV infection. Care coordination consists of goal-oriented activities that locate or create, facilitate access to, coordinate, and monitor the full range of HIV-related health and human services. The purpose is to encourage the cost-effective use of medical and community resources and to promote the well being of the individual while assuring the individual's freedom of choice. To assure freedom of choice, the individual signs a *Freedom of Choice/Intent to Participate Form* acknowledging an understanding of the services provided and identifying the chosen care coordination provider. Care coordination services are those that assist Traditional Medicaid-eligible people from the targeted group to access needed medical, psychological, social, educational, and other services.

To be eligible for reimbursement for care coordination, a member must be a Traditional Medicaid member and have a documented HIV infection. There must be medical documentation or verification of medical diagnosis of HIV infection in the member's care coordination file. The diagnosis can be verified with the following types of documentation:

- Confidential, positive HIV test result
- A physician's statement
- Hospital discharge statement or other medical reports that verify the diagnosis
- Medical prescription for AZT, ddI, or ddC, or copy of approval for participation in the AIDS Drug Assistance Program (ADAP) or the Early Intervention Program (EIP)

Other Health-Related Programs Administered by the Indiana Family and Social Services Administration

Hoosier Assurance Plan

This plan is administered by the Division of Mental Health and Addiction (DMHA). Children and youths are eligible for enrollment in the Hoosier Assistance Plan if they have a psychiatric diagnosis, functional impairment (as identified through the use of a DMHA-approved assessment tool), and family income below 200% of the Federal Poverty Level (FPL). Throughout the year, providers submit names of eligible individuals for enrollment through the DMHA Community Services Data System (CSDS). DMHA pays providers a risk-adjusted case rate per individual enrolled, up to the maximum contract amount for each enrolled population. In turn, providers are responsible for making available to the enrolled individual a full range of psychiatric services.

Hoosier Assurance Plan (Substance Abuse Services)

Certified substance abuse treatment services can be provided to children with a DSM-IV diagnosis when the family income is below 200 percent of the FPL. When funding is available, services can begin within one week after eligibility determination. Treatment includes planning, crisis intervention, case management, outpatient and intensive outpatient, acute stabilization including detoxification, residential, day treatment, medical evaluation, and family support services. f funds are not allocated or are depleted during the fiscal year, a wait list is available.

Alcohol, Tobacco, and Other Drug Prevention Services

Prevention providers are state agencies and community-based, not-for-profit agencies under contract with the Division of Mental Health and Addiction (DMHA).

Teen and middle level leadership training is available through the Juvenile Justice Task Force, Inc.

After-school substance abuse prevention programs are provided for youth 10 through 14 years of age from 3 p.m. to 6 p.m. in the winter months, and from 12 p.m. to 6 p.m. in the summer. *Focused* prevention programs, such as normative education about drug use, and *supportive* prevention programs, such as after-school tutoring, are among the categories of service made available by providers for selection by parents and children.

The Indiana Prevention Resource Center (IPRC) provides the Regional Alcohol and Drug Awareness Resource site for prevention providers. The PRC maintains a Web site at www.drugs.indiana.edu.

The state requires after-school program contractors to acquire specified levels of competence from prevention providers. An independent, not-for-profit organization, the Indiana Prevention Professionals, Inc., coordinates courses for individuals to acquire credentials as prevention professionals. Courses are offered at Ball State University, Indiana University, Indiana University Purdue University Indianapolis, and Purdue University. Distance learning is available through Western Kentucky University and Ball State University.

Healthy Families

Healthy Families is a postnatal program for first-time families, is provided in counties by offices of the Division of Family and Children. Prevention services are population-based for moderate-risk, 10 to 14 year olds. Funding is provided for participants with incomes below 200 percent of the FPL.

Additionally, Prenatal Substance Use Prevention Program (PSUPP) is an education-based program provided by the Indiana State Department of Health (ISDH) through its regional offices.

Step Ahead

The Step Ahead initiative provides planning grants to help counties develop local Step Ahead Councils and establish a local process for seamless delivery systems for human services. These grants, along with training and technical assistance from the Office of Community Planning, act as strong incentives for local leadership forums to implement county-level systems. The Office of Community Planning assists the councils in obtaining education around planning issues, creative problem solving, and continual information sharing, as well as coordinating the development of 16 PBS training videos.

First Steps

Children younger than three years old are eligible for First Steps if the multidisciplinary team determines they have any one of the following conditions:

- Disabilities due to developmental delay
- A physical or mental condition that has the probability of resulting in developmental delay
- Being at risk of having substantial delays due to biological risk factors, as documented by a physician, that would cause or contribute to a developmental delay
- When a child is enrolled in the IHCP or Children's Special Health Care Services, all First Step services are authorized and reimbursed through First Steps

The First Steps system is administered at the local level by a System Point of Entry (SPOE) that has been selected by the local First Steps planning and coordinating council. FSSA has a contractual relationship with the entities selected to serve as the System Point that authorizes them to act as the local lead agency. The SPOE is staffed by an intake-coordinator with responsibility for facilitation of eligibility determination and development of a service plan.

Services that are required to be available for enrolled children are:

- Speech therapy
- Occupational therapy
- Physical therapy
- Developmental therapy
- Social work
- Psychological services
- Nutrition
- Health
- Nursing
- Medical diagnostics
- Audiology
- Vision services
- Assistive technology
- Service coordination

- Transportation
- Family training and counseling

Indiana State Department of Health Programs

Vaccines for Children

The federal Vaccines for Children (VFC) Program supplies, at no charge, vaccines against various childhood diseases to VFC-enrolled providers. All Hoosier Healthwise enrollees ages 18 years and younger are eligible to receive free VFC vaccines.

Children's Special Health Care Services

Children's Special Health Care Services (CSHCS) serves persons from birth to 21 years old. The current financial eligibility standard for the program is 250 percent of the federal poverty level. CSHCS provides a basic service package and a limited service package to help meet the needs of CSHCS clients. The basic service package for medically and financially eligible children includes primary care (preventive care, immunizations, and sick-child care). It also includes routine dental care and the provision of prescription medication. The limited service package consists of services that must be related to the child's eligible medical condition(s) including the following:

- Inpatient hospitalization
- Surgery
- Therapies
- Dental services (other than routine care)
- Emergency services

Currently, CSHCS has provider agreements with primary, specialty, and dental practitioners throughout Indiana to provide direct medical services. The CSHCS Program pays for medical services at Medicaid rates. However, the ISDH is moving away from direct service provision and is beginning to offer care coordination at the community level through contractors. Benefits are coordinated among the CSHCS, Hoosier Healthwise, and First Steps programs for children eligible for more than one of these programs.

Maternal and Child Health

Maternal and child health (MCH) is a program funded by a block grant. Local service providers consist of health departments, not-for-profit agencies, hospitals, and social services agencies. MCH programs include primary care medical services, well-baby services, well-child services, immunizations, treatment for minor illnesses, and referral for complicated or chronic illness. Clients can also receive social services and nutritional counseling as needed.

MCH programs are available to all women and children; however, the program targets women of childbearing age, families with incomes less then 250 percent of the FPL, and those who do not have access to health care. If family income is less than 100 percent of the FPL, services are free. Many MCH providers have agreements with Hoosier Healthwise PMPs to provide services to Hoosier Healthwise managed care members.

MCH manages the toll-free Indiana Family Helpline referral service from the offices of the ISDH. Hoosiers may call this toll-free number to find out where health and social services are available and to request assistance in scheduling appointments or transportation services. MCH provides training for prenatal substance abuse prevention, education for care coordinators, and education for prevention of childhood lead poisoning.

Special Supplemental Program for Women, Infants, and Children

The county Women, Infants, and Children (WIC) offices administer this program. The purpose of WIC is to improve participants' health and quality of life by providing nutrition education and counseling, medical and social referrals, and supplemental food to eligible women and children. To qualify for WIC, participants must meet the following three criteria:

- Be an Indiana resident
- Have an income at or below 185 percent of the FPL
- Be at medical or nutritional risk

Participants are limited to pregnant women, breast-feeding women up to one year after delivery, postpartum women up to six months after delivery, infants, and children younger than five years old.

Immunization Program

The immunization program is an ISDH program operated through 94 local health departments, 71 public health clinics, and about 1,000 primary care physicians. Eligibility is determined by the parent or guardian's completion of the Vaccine Administration Consent form and, if applicable, the VFC eligibility form.

Indiana Childhood Lead Poisoning Prevention Program

Indiana Childhood Lead Poisoning Prevention Program (ICLPPP) blood lead screening is provided to children from birth to six years old at local health departments and MCH/WIC sites. Blood lead levels are analyzed by the ISDH lead laboratory and reported to the health care provider. If the child has an elevated blood lead level, the provider is alerted to begin follow-up activities. Medical supplies, postage, training, and environmental inspections are provided. Blood draws for IHCP enrollees can be billed to the IHCP.

The ICLPPP office provides educational brochures, videos, and data to local health departments, health care providers, the public, and the media. Lead poisoning prevention brochures are also available from the Indiana Housing Authority.

Teen Pregnancy Prevention and Indiana RESPECT

Indiana RESPECT is a program funded by the ISDH. Fund grantees provide sexual abstinence education and adolescent pregnancy prevention education. This education follows specific federal and state guidelines.

Indiana Minority Health Coalition

The Indiana Minority Health Coalition (IMHC) is composed of local minority health coalitions in the following counties and areas: Allen, Delaware, Elkhart, Grant, Howard, Lake, LaPorte, Madison,

Marion, St. Joseph, Tippecanoe, tri-county of southern Indiana, Vanderburgh, Vigo, and Wayne. The IMHC operates under the ISDH and was created to improve the health status of at-risk Indiana racial minorities. This statewide network of coalitions promotes healthy lifestyles through local disease prevention, health awareness, referral and information resources, and community outreach and program services. The IMHC also maintains a central registry of immunization records and makes this information available via a toll-free phone line. The Minority Health Coalition collaborates with Hoosier Healthwise to enroll children in Indiana.

Healthy Start-Lake County

Healthy Start-Lake County is a northwest Indiana Health Department Cooperative program. Services are provided in the following cities: East Chicago, Gary, Hammond, and Lake Station. The services include:

- Case management
- Community outreach and care coordination
- Health education
- Transportation
- Prenatal and postpartum medical referral and care
- Pregnancy testing

Services are provided to pregnant women, postpartum women, and infants up to one year of age. Several health education classes are offered including the following:

- Prenatal and postpartum care
- Infant development
- Smoking cessation
- Contraception
- Breast feeding
- Parenting
- Lamaze childbirth techniques

Health care for infants up to one year is provided through an agreement with child health care providers, including several Maternal and Child Health clinics and hospital clinics.

Family Planning

Family planning provides physical exams, family planning counseling, and contraceptive supplies. Ancillary services include nutritional assessment and counseling, psychosocial assessment, counseling and referral, and health education on a variety of topics (such as Breast Self-Exam, sexually transmitted diseases, substance abuse prevention, smoking cessation, folic acid, and so forth).

The target population is low-income (less than 250 percent of the FPL) women of childbearing age (primarily ages 15-44 years).

Other Health-Related Programs for Targeted Populations

Healthy Start-Marion County

Health and Hospital Corporation of Marion County coordinates 15 subcontractor community agencies. Services are offered to pre-adolescents and adolescents ages 10-19. Some of the collaborating agencies offer programs to only male or female adolescents. There are also programs directed to the parents of adolescents.

Indiana Perinatal Network

The Indiana Perinatal Network (IPN) is a non-profit organization with an advisory board that includes staff from the ISDH and the FSSA, as well as the March of Dimes. IPN administers the *Baby First* media campaign and participates in professional development activities in the area of perinatal health. An IPN newsletter and online magazine provides information to promote healthier mothers and babies. IPN monitors the ISDH's outcome measures for low birth weight babies and infant mortality to evaluate the effectiveness of outreach efforts.

Wishard Hispanic Health Project

The Wishard Hispanic Health Project offers health services to low income Hispanics. This program collaborates with Hoosier Healthwise for outreach and children's enrollment.

Hispanic Center

The Hispanic Center offers information and referrals to health care, WIC, immunizations, and dental care for Hispanic women who are of reproductive age, expecting, or with school-aged children.

Black and Minority Health Fair

The Black and Minority Health Fair is a fixture of ISDH for the past 14 years. This health fair is the "largest health fair focusing on minority health issues" in the United States. The annual Black and Minority Health Fair's objective is to improve the health of minorities throughout Indiana and surrounding states by providing health screenings and education information. Each participant has the opportunity to receive more than $500 worth of medical screenings as well as health information and education at no charge.

Other Types of Assistance Programs

Food Stamps

Food stamps are available through the county offices of the Division of Family and Children. Eligibility is determined through an interview with the applicant or the applicant's representative regarding relevant financial and non-financial information. Interviews can be face-to-face or by telephone. The average application processing time is 12 calendar days. Financial eligibility is based on the evaluation of income and assets. The net income eligibility standard is equal to 100 percent of the FPL. Nonfinancial eligibility requirements include citizenship or legal alien status, state residency,

the presence of a Social Security number, and cooperation with employment and training requirements. Each month, the food stamp program serves approximately 135,620 children younger than 18 years old.

Free and Reduced School Breakfast and Lunch Programs

The Division of School and Community Nutrition Programs contracts with school corporations and child care centers to participate in the Child Nutrition Programs. Contractor entities provide each household with an application for free or reduced price meal benefits. Services to eligible participants include the National School Lunch Program, the School Breakfast Program, Special Milk Program, Food Distribution Program, and Supplemental Food Program (Child and Adult Care Food Program only). Children with family incomes below 130 percent of FPL are eligible for free meals; children with family incomes below 185 percent of FPL are eligible for reduced price meals.

Child Care Development Fund Voucher Program

Child Care Development Fund Voucher Program (CCDF) is administered at the county level through voucher agents. TANF recipients are eligible by virtue of their TANF status; other applicants must be at or below 143 percent of the FPL and have established a need for the service. Approximately 47,000 children between birth and 13 years of age are currently being served, including few special needs children up to 18 years old. Large waiting lists exist, primarily in urban areas. Waiting lists occur due to a lack of funding in a specific county.

School-Age Child Care

CCDF provides childcare to low-income families locally through voucher agents. TANF recipients are eligible by virtue of their TANF status; other applicants must be at or below 143 percent of the FPL and have established a need for the service. Local service providers maintain their own waiting lists.

Special Education Preschool

The following public or private entities have direct or delegated authority to provide special education and related services:

- Public school corporations operating programs individually or cooperatively with other school corporations
- State developmental centers and hospitals operated or supported by the Division of Mental Health or Division on Developmental Disabilities of the FSSA
- State schools and programs operated by the ISDH
- Programs operated by the Department of Correction
- Private schools and facilities that serve students referred or placed by a public school corporation, the Division of Special Education (IDOE), or the Division of Family and Children

Special education is specially designed instruction, provided at no cost to the parent, to meet the unique needs of a student, and may include the following:

- Classroom instruction
- Community-based instruction
- Instruction in hospitals, nursing homes, or other institutions

- Homebound or home-based instruction
- Instruction in physical education, vocational education, or speech-language therapy

Related services include, but are not limited to the following:

- Assistive technology devices and services
- Audiological services
- Counseling; early identification
- Medical services for evaluation
- Occupational therapy
- Parent counseling and training; physical therapy; psychological services
- Recreation
- School health services
- Social work services in schools
- Transportation
- Rehabilitation counseling

Eligible students must have one of the following disabilities and need special education and related services:

- Autism
- Communication disorder
- Dual sensory impairment
- Emotional handicap
- Hearing impairment
- Learning disability
- Mental handicap
- Multiple handicap
- Orthopedic impairment
- Other health impairment
- Traumatic brain injury
- Visual impairment

Early childhood special education services are limited to students three to five years old who meet the State's early childhood criteria and are suspected of having one of the disabilities listed. Special education is provided for all students between three and 22 years old.

Head Start

The Department of Health and Human Services (HHS) contracts directly with local grantees for Head Start programs. All grantees must be private, nonprofit entities with proven records of fiscal accountability that enforce the federally established Head Start performance standards and policies. All 92 Indiana counties have grantees for a three-to-five-year-old program. The only new grantees

may be funded for Early Head Start. Head Start programs provide services as defined in the federal performance standards. These services normally involve the following:

- Developmentally appropriate early childhood education
- Health and nutrition services
- Social services
- Family literacy programs
- Parent involvement, education, and leadership opportunities
- Disability services
- Transportation for children

Most programs have a waiting list with numbers varying from county to county.

Temporary Assistance to Needy Families

County offices of the DFC administer the Temporary Assistance to Needy Families (TANF) program that provides temporary cash assistance to eligible families. Eligibility is determined through an interview with the applicant or applicant's representative regarding relevant financial and non-financial information. The average time for processing an application is approximately 20 calendar days. Cash assistance is provided to eligible families with dependent children in the home who are younger than 18 years old. Employment and training services are also provided to promote self-sufficiency of the child's parent or caretaker in the home.

Public Information Resources

Baby First Campaign

The Indiana Perinatal Network (IPN) provides services targeted at improving the health of pregnant women and babies. It offers the following services:

- Educational messages about the importance of prenatal care and a healthy lifestyle
- A *call to action* encouraging women to call the Indiana Family Helpline to register for *Baby First* and to receive information and assistance
- An educational packet, including a videotape, coupons, and other incentives, mailed to each *Baby First* respondent
- Follow-up to ensure access to services

The media campaign advertising the availability of *Baby First* materials and providing educational information includes television, radio, print advertising, billboards, bus placards, incentives (coupons, videotape, free products), other print media (newspaper and magazines), and printed educational materials to reach all pregnant women in Indiana.

Indiana Family Helpline

The Indiana Family Helpline is a statewide information and referral service that assists in promoting and facilitating access to MCH, WIC, CSHCS, and other state programs.

Helpline communication specialists are trained to provide callers with information and assistance on the following programs:

- IHCP, including information on eligibility determination, service delivery location, appointment scheduling, arranging transportation for Medicaid, Hoosier Healthwise, HealthWatch/EPSDT, and Medicaid waiver services
- First Steps
- Step Ahead
- Day care centers
- Prenatal care providers
- Homes for pregnant teens
- Car seat loan
- Developmental screening
- Support groups for adolescents
- CHOICE
- Respite care
- Children in Need of Services (CHINS)
- Financial assistance

The following *special campaigns* have displayed the toll-free number in brochures, television advertisements, and so forth:

- Building Bright Beginnings
- 1-800-BABY (Healthy Start)
- CHIP and HealthWatch/EPSDT
- Ask for the Sake of our Kids
- Cancer
- Indiana perinatal prevention
- Folic acid
- Osteoporosis prevention
- Lead poisoning program
- WIC

Information about callers is sent to the coordinator of each of the programs.

Building Bright Beginnings

Building Bright Beginnings is an initiative targeting children from birth to four years old to ensure that factors impacting children's development are positive and supportive. Services are not provided directly to participants. The initiative focuses on responsible parenting, health and protection, quality childcare, and community mobilization.

Outreach and education are the primary focuses of Building Bright Beginnings. The following activities are included:

- *Parent packets:* Packets that include a developmental calendar and are distributed by all delivery hospitals in Indiana
- Brochures
- Public service announcements
- *Seek and Demand Quality Child Care and Education*: Public service announcements with brochures for distribution to parents
- Web site at www.ai.org/gov/BBB
- Caller information through the toll-free Indiana Family Helpline

Indiana Black Expo

Since 1998, Indiana Black Expo, Inc., (IBE) has worked in collaboration with many agencies to market and promote the Hoosier Healthwise for Children Program. IBE is a non-profit community service organization that serves as a channel for communications and a catalyst for greater harmony within communities throughout Indiana and the nation. Today, IBE has grown from a single annual event to a year-round, multifaceted community service organization. IBE sponsors major programs and year-round events including the Youth Video Institute (YVI), Father-to-Father, Cool-n-Smart, We Can Feed The Hungry Program, Project Soar, and an annual scholarship program.

Glossary

The following is a list of terms and abbreviations commonly used in this HealthWatch/EPSDT supplemental manual. An expanded glossary is found in the Indiana Health Coverage Programs Provider Manual.

AAP	American Academy of Pediatrics
AAS	Atomic absorption spectrophotometer
ADA	American Dental Association
AFDC	Aid to Families with Dependent Children and was replaced by Temporary Assistance to Needy Families (TANF)
BA	Benefit advocate
CHIP	Children's Health Insurance Program
CMS	Centers for Medicare and Medicaid Services, formerly known as the Health Care Financing Administration (HCFA)
CMS-1500	Approved claim form used to bill professional services, formerly known as the HCFA-1500 claim form
CPT	Current procedural terminology
CSHCS	Children's Special Health Care Services
DDST	Denver Developmental Screen Test
DFC	Department of Family and Children
ELISA	Enzyme Linked Immunosorbent Assay
EPSDT	Early and Periodic Screening, Diagnosis, and Treatment Program (also known as HealthWatch in Indiana)
FPL	Federal Poverty Level
FS	First Steps
HCFA	Health Care Financing Administration, now known as the Centers for Medicare and Medicaid Services (CMS)
HCFA-1500	Approved claim form used to bill professional services, now known as the CMS-1500 claim form
HCPCS	Health Care Common Procedure Coding System
HIPAA	Health Insurance Portability and Accountability Act

HIV	Human Immunodeficiency Virus
HRR	High Risk Register (In relation to audiological screening)
IAC	Indiana Administrative Code
ICLPPP	Indiana Childhood Lead Poisoning Prevention Program
IEP	Individualized education plan (describes services provided under Public Law 99-457)
IFSP	Individualized family service plan (describes services provided under Public Law 99-457)
IPAC	Immunization Practice Advisory Committee
ISDH	Indiana State Department of Health; previously known as Indiana State Board of Health
MCE	Managed care entity; responsible for a managed care delivery system (RBMC or PCCM)
MCO	Managed care organization
OMPP	Office of Medicaid Policy and Planning
PCCM	Primary Care Case Management; a component of the managed care program, Hoosier Healthwise; also known as PrimeStep
PMP	Primary medical provider
RBMC	Risked-based managed care; a component of the managed care program
SMR	Sexual maturity ratings
TANF	Temporary Assistance to Needy Families; formerly Aid to Families with Dependent Children (AFDC)
TPL	Third Party Liability
VFC	Vaccines for Children

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